

DR. HINMELRIGHT

2345

CERTIFICATE OF DEATH

02340

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 508 36 MARYLAND AVENUE	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle P. Last BOWEN		4. DATE OF DEATH Month MARCH Day 22 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 21, 1867
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNABLE TO WORK - Odd jobs for Self		10b. KIND OF BUSINESS OR INDUSTRY Springfield, West Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DR. CHARLES J. BOWEN		14. MOTHER'S MAIDEN NAME MARY K. PARSONS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sublethal Hemorrhage 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma stomach DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 days (31)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/17 , 19 56 , to 3/22 , 19 56 , that I last saw the deceased alive on 3/21 , 19 56 , and that death occurred at 5:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George M. Simons		DATE SIGNED 3/22/56	
PHYSICIAN'S NAME (Type) George M. Simons, M.D.		ADDRESS (Street, city or town, state) Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-56	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24a. REC'D BY REGISTRAR March 23, 1956	
24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.			

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE

PLACE

CAUSE

ICD-9 CODE

SEX

RACE

AGE

EDUCATION

RELIGION

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DEATH CERTIFICATE

BUREAU V. S.

MAR 27 1956

RECEIVED

2407

CERTIFICATE OF DEATH

02341

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		d. STREET ADDRESS <u>207 Center St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Alvin</u> Middle <u>R.</u> Last <u>Bowser</u>		4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-1898</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>	
11. BIRTHPLACE (State or foreign country) <u>Meyersdale, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Bowser</u>		14. MOTHER'S MAIDEN NAME <u>Annie Bowman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-10-4016</u>	
17. INFORMANT <u>Ward Bowser, 207 Center St. Frostburg</u>		Address <u>Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> DUE TO (b) <u>Hypertensive Cardiovascular</u> DUE TO (c) <u>Penal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>year or two</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 31</u> , 19 <u>56</u> , to <u>March 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 23</u> , 19 <u>56</u> , and that death occurred at <u>6:58</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Davis, M.D.</u>		DATE SIGNED <u>3/26/56</u>	
PHYSICIAN'S NAME (Type) <u>John B. Davis, M.D.</u>		<u>2 Broadway, Frostburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-26-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. B. Mattingly</u>		ADDRESS <u>Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>3-26-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harry N. Roe</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

APR 4 1956

RECEIVED

4 Feb

BUREAU V. S.

MAR 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2347

CERTIFICATE OF DEATH

02343

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 62 CUMBERLAND				c. LENGTH OF STAY IN 1b 16 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 MEMORIAL HOSPITAL				e. STREET ADDRESS RT. #3 BEDFORD ROAD			
3. NAME OF DECEASED (Type or print) First Middle Last MILDRED LUCETTA BRADY				4. DATE OF DEATH Month Day Year MARCH 12 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 22, 1918	9. AGE (In years last birthday) yrs. 37	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper at				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
10c. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HENRY COLEMAN				14. MOTHER'S MAIDEN NAME GRACE BUTLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-20-7181		17. INFORMANT Address Walter W. Brady Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure Cardiac Hypertrophy 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Endocarditis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1951	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombolytopenic Purpura						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1-9- , 19 51 , to 3-11-56 , that I last saw the deceased alive on 3-11-56 , and that death occurred at 8:35 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. J. Williams M.D. Cumberland				ADDRESS (Street, city or town, state) Cumberland, Md.			
DATE SIGNED 3-12-56							
PHYSICIAN'S NAME (Type) WILLIAM F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/56		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 14, 1956	
				24b. REGISTRAR'S SIGNATURE W.R. Brady, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED

DECEASED

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

AGE

AGE

AGE

SEX

SEX

SEX

CAUSE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

BUREAU V. S.

JAN 16 1956

RECEIVED

2348

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY X ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLERSLIE			
c. LENGTH OF STAY IN 1b 16 HRS.				d. STREET ADDRESS Box 154 Ellerslie, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MRS.		First CLARA		Middle B.		Last BREESE	
4. DATE OF DEATH		Month MARCH		Day 9		Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 4, 1896		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) W.VA. St. Leo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM CAMP				14. MOTHER'S MAIDEN NAME Lavenia DELANEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Chronic Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Bronchopneumonia DUE TO (c) Chronic Bronchopneumonia						INTERVAL BETWEEN ONSET AND DEATH 8 days 18 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 Mar , 19 56 , to 9 Mar , 19 56 , that I last saw the deceased alive on 9 Mar , 19 56 , and that death occurred at 12:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 So Centre St, Cumberland, Md DATE SIGNED 10 Mar 56							
ACTUAL SIGNATURE James G. Stegmaier		M.D. 122 So Centre St, Cumberland, Md					
PHYSICIAN'S NAME (Type) James G. Stegmaier							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/56		22c. NAME OF CEMETERY OR CREMATORY Prosperity Cem.		22d. LOCATION (City, town, or county) (State) Prosperity, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 12, 1956	
				24b. REGISTRAR'S SIGNATURE W.R. Frantz M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ALABAMA

MOBILE

WILLIAM TAYLOR

INTERNAL

1900

GENERAL HOSPITAL

WHITE

MALE

AGE

DATE

WILLIAM TAYLOR

WHITE

MALE

U.S.A.

WILLIAM TAYLOR

DATE

WILLIAM TAYLOR

WILLIAM TAYLOR

WILLIAM TAYLOR

GENERAL HOSPITAL, MOBILE, ALA.

BUREAU V. S.

MAR 18 1956

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

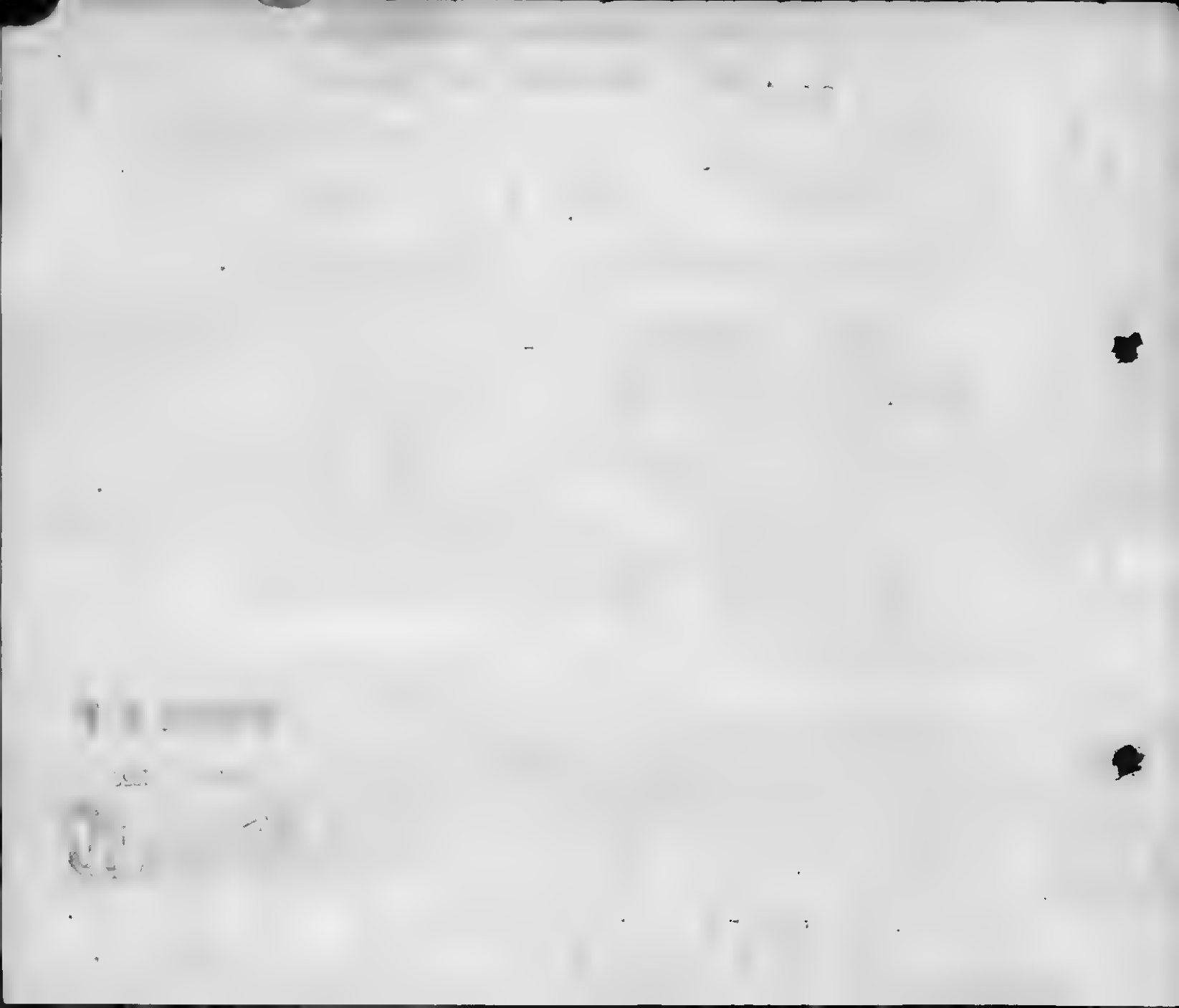
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2408 CERTIFICATE OF DEATH

02345

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		LENGTH OF STAY (in this place) <u>5 wks.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>Washington St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>EUGENE BRUNER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 12, 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>11-18-1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer-Dye House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Donahue</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-10-2125A</u>		17. INFORMANT & ADDRESS <u>Wm. Bruner, Pittsburgh, Pa.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4-1-1 IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 wks -</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bronchial asthma</u>				<u>years -</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic heart disease</u>				<u>years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1953</u> , to <u>3/12/56</u> , that I last saw the deceased alive on <u>3/12/56</u> , and that death occurred at <u>5:58 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John B. Davis</u> M.D.				ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>		DATE SIGNED <u>3/14/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR <u>J. R. Durst</u>		REGISTRAR'S SIGNATURE <u>J. R. Durst</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u> ADDRESS <u>Frostburg, Md.</u>			



CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PETERSBURG	
c. LENGTH OF STAY IN 1b 16 DAYS		d. STREET ADDRESS 11 CENTRAL AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BETTIE GOLDIZEN BURGESS		4. DATE OF DEATH Month Day Year MARCH 27 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-1889
9. AGE (In years last birthday) 66 67		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHRISTOPHER GOLDIZEN		14. MOTHER'S MAIDEN NAME ANNIE RIGGLEMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEMORIAL HOSPITAL—MEMORIAL & WARWICK AVES.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism, recurrent, massive DUE TO (b) Pulmonary embolism with infarction, at base DUE TO (c) Contusion left chest wall, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 20 minutes 17 days 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fell against banister	
20c. TIME OF INJURY, Month, Day, Year, Hour, Minute, Second Before death 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 mn. 1956, to 27 mn. 1956 that I last saw the deceased alive on 26 mn. 1956, and that death occurred at 5:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. A. Van Ormer M.D.		ADDRESS (Street, city or town, state) CUMBERLAND, MD. DATE SIGNED 27 Jan. 56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 29, 1956	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) (State) Petersburg W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Address		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02347

DR. BALLIN

2350

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL - MEMORIAL AVE.		d. STREET ADDRESS 196 MAIN STREET	
3. NAME OF DECEASED (Type or print) First JOHN Middle COBURN Last BYER		4. DATE OF DEATH Month MARCH Day 31 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 25, 1879
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	11. IF UNDER 24 HRS Months 76 Days 76 Hours 76 Min. 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Pipe fitter	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY BYER		14. MOTHER'S MAIDEN NAME AGNES LOVE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-4250	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Incarcerated in prison for 1 year		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-1 , 1954 , to 3-31 , 1956 , that I last saw the deceased alive on 3-31 , 1956 , and that death occurred at 10:25 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 62 Green St. Cumberland, Md. DATE SIGNED 4-2-56	
ACTUAL SIGNATURE Ralph W. Ballin		PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 3, 1956	
22c. NAME OF CEMETERY OR CREMATORY Lybarger Lutheran Cem.		22d. LOCATION (City, town, or county) (State) Madley Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR April 3, 1956		24b. REGISTRAR'S SIGNATURE W. L. Frantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

RECEIVED
JAN 10 1911

2351

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 Cumberland.</u>			c. LENGTH OF STAY IN 1b <u>3 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>			d. STREET ADDRESS <u>Little Orleans</u>		
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Bernadine</u> Last <u>Callen</u>			4. DATE OF DEATH Month <u>3/</u> Day <u>4/</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/13/76</u> <u>xx/xx/xx</u>		9. AGE (In years last birthday) <u>80 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland, Little Orleans</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Higgins</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Reel</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Patient's Chart</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>440.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>5 yrs.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>p. m.</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>March 1, 1956</u> to <u>March 5, 1956</u> that I last saw the deceased alive on <u>March 4, 1956</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>J. T. Johnson</u>		ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u>		DATE SIGNED <u>3-5-56</u>	
PHYSICIAN'S NAME (Type) <u>J. T. JOHNSON, JR., M.D.</u>		<u>CUMBERLAND, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/7/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HAFER, John J. Hafner</u>		ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>March 8, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>W. R. Tandy, M.D.</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

1936

100

2352
CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS MC HENRY	
3. NAME OF DECEASED (Type or print) First FRANK Middle CALLIS Last CALLIS		4. DATE OF DEATH Month MARCH Day 21 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 10, 1868
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer & Carpenter for Self		10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME EDWARD CALLIS		14. MOTHER'S MAIDEN NAME HANNAH BULLOUGH Anna Bullough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT MEMORIAL HOSPITAL-WARWICK AND MEMORIAL AVE.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Arteriosclerosis with 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-15-1956 to 3-21-1956 that I last saw the deceased alive on 3-21-1956 and that death occurred at 4:02 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED Howard L. Tolson, M.D.	
ACTUAL SIGNATURE Howard L. Tolson M.D.		PHYSICIAN'S NAME (Type) Howard L. Tolson, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 24, 1956	
22c. NAME OF CEMETERY OR CREMATORY Hoyes Cemetery		22d. LOCATION (City, town, or county) (State) Hoyes, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Donald Newman ADDRESS Greenville Md		24a. REC'D BY REGISTRAR March 23, 1956 24b. REGISTRAR'S SIGNATURE Walter K. Hantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

72

from the

600

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2353 CERTIFICATE OF DEATH

Reg. Dist. **02350**

Within corporate limits W F WMS.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE W VA. b. COUNTY Hampshire	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS BURLINGTON W VA.	
3. NAME OF DECEASED (Type or print) First JAMES Middle W Last CARSKADON		4. DATE OF DEATH Month MARCH Day 30 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1865 DEC. 12, 1865
9. AGE (In years last birthday) 90		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Headsville, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISAAC CARSKADON		14. MOTHER'S MAIDEN NAME SUSAN SHEETZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Memorial Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) For advanced generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Supraventricular origin			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3:28 , 1956 to 3:31 , 1956 ; that I last saw the deceased alive on 3:31 , 1956 , and that death occurred at 1:21 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3-31-56			
ACTUAL SIGNATURE W. F. Williams, M.D.			
PHYSICIAN'S NAME (Type) W. F. Williams, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 3, 1956	22c. NAME OF CEMETERY OR CREMATORY Headsville Church Cem.	22d. LOCATION (City, town, or county) (State) Headsville, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Markwood Funeral Home, Keyser, West Virginia		24a. REC'D BY REGISTRAR April 2, 1956	
		24b. REGISTRAR'S SIGNATURE W. K. Frantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. R.

APR 4 1900

RECEIVED

2354

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>		2. USUAL RESIDENCE HOME OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Barton</u> STREET (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Martha</u> (First) <u>Chappell</u> (Middle) (Last)		4. DATE OF DEATH <u>Mar.</u> <u>23</u> <u>19 56</u> (Month) (Day) (Year)	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Aug. 6 - 1875</u>
9. AGE last birthday <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Barton Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James O. Neal</u>		14. MOTHER'S MAIDEN NAME <u>Martha Biggs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>W. H. Chappell</u> <u>431 Cumberland ST.</u> <u>Cumberland MD.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
1. IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage.</u>		<u>7 days.</u>	
2. ANTECEDENT CAUSE(S) DUE TO <u>Cerebral arteriosclerosis</u>		<u>?</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Chronic Myocarditis</u>		<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile psychosis.</u>		<u>6 mos.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 2, 1956</u> , to <u>Mar. 23, 1956</u> , that I last saw the deceased alive on <u>Mar. 23, 1956</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>James E. McLean, M.D.</u>		DATE SIGNED <u>3-23-56</u>	
ADDRESS (Street, city, town, state) <u>44 Green St.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-26-56</u>	
NAME OF CEMETERY OR CREMATORY <u> Laurel Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Marshall, Ind</u>	
24. REC'D BY REGISTRAR <u>Walter R. Lantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Baal, Westport, Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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U. S. A.

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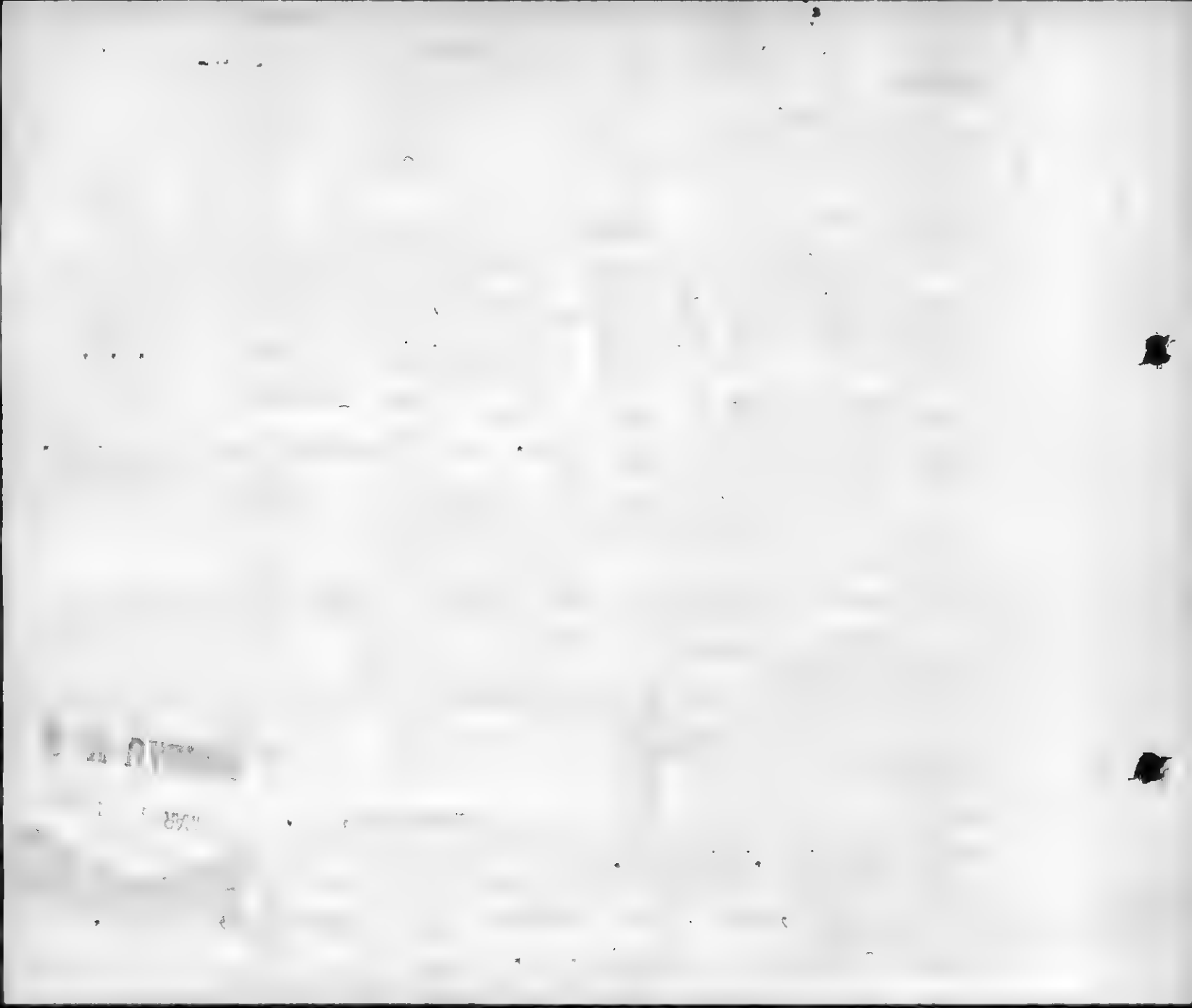
2419 CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE [Where deceased lived If institution. Residence before admission] a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				c. LENGTH OF STAY IN 1b 79 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Nancy Middle Clupp Last Clupp				4. DATE OF DEATH Month March Day 5 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1876		9. AGE (In years last birthday) 79 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Coleman				14. MOTHER'S MAIDEN NAME Margaret Matthews Murphy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Mrs. Pauline Matthews Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential hypertension DUE TO (c) Chronic asthma						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Lonaconing, MD.		20g. (County) (State)	
21. I certify that I attended the deceased from Jan 21 , 1956, to Mar 5 , 1956, that I last saw the deceased alive on Mar 5 , 1956, and that death occurred at 10:30 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) Lonaconing, MD. DATE SIGNED							
ACTUAL SIGNATURE Leslie R. Miles Jr. M.D.							
PHYSICIAN'S NAME (Type) Leslie R. Miles Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF MAR 7, 1956		22c. NAME OF CEMETERY OR CREMATORY Philes Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE 3-7-56	
				24b. REGISTRAR'S SIGNATURE Jannette M. Pool			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2355 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home 114 Seymour Street</u>		d. STREET ADDRESS <u>114 Seymour Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>M</u> Last <u>Codire</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1882</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Peter Codire</u>		14. MOTHER'S MAIDEN NAME <u>Mary Clancy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-05-5290</u>	
17. INFORMANT <u>Mrs. Regina Codire, 114 Seymour St., City.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-8-1954</u> to <u>3-11-1956</u> , that I last saw the deceased alive on <u>3-11-1956</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>L. Brings</u> M.D.		PHYSICIAN'S NAME (Type) <u>L. Brings, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 14, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>March 13, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. Frank, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2356

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>17 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>Wellington</u> Last <u>Conner</u>		4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 5-1904</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Textile worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Id.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Conner</u>		14. MOTHER'S MAIDEN NAME <u>Martha Groom</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>217-10-6355</u>	
17. INFORMANT <u>Memorial Hospital, Cumberland, Id.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Myocardial infarction</u> (c) <u>Pulmonary edema & congestion.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>17 hours</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Denning M.D.</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Denning M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 20-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 23, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>near Hyndman, Pennsylvania.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Zeigler, Hyndman, Pennsylvania.</u>		24a. REC'D BY REGISTRAR <u>March 21, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. L. Krantz, M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, marking the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

3-1-11

10-1-11

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2409 CERTIFICATE OF DEATH

02355

Items 9, 11 Film G194 3-19-56 et

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harry & Allegany</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		STATE <u>MD</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>422 Spruce St</u>		LENGTH OF STAY (in this place) <u>60 yrs</u>		STREET ADDRESS (If rural give location) <u>422 Spruce St</u>			
3. NAME OF DECEASED (First) <u>HARRY</u> (Middle) <u>OSBORNE</u> (Last) <u>COOK</u>				4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>10</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>August 7, 1897</u>	9. AGE last birthday <u>58</u> yrs.	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-Rex. Cennese Corp</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BARTON, MD</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Cook</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Spencer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-01-9024 A</u>		17. INFORMANT & ADDRESS <u>403 Maryland Ave Westernport, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Nephritis</u>				<u>5 Years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio-Sclerosis</u>				<u>5 Years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Lobar Pneumonia</u>				1 Day			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		21b. PLACE (Home, farm, factory, or injury street, office bldg., etc.) <u>None</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 10, 1951</u> to <u>Mar 10, 1956</u> , that I last saw the deceased alive on <u>Mar 10, 1956</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul R. Wilson</u> M.D.		ADDRESS (Street, city, town, state) <u>Piedmont W. Va.</u>		DATE SIGNED <u>12 Mar. 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>13 MAR 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		LOCATION (City, town, or county) <u>Westernport MD</u>	
24. REC'D BY REGISTRAR <u>3-13-56</u>		REGISTRAR'S SIGNATURE <u>Mr. J. C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Bunk</u>		ADDRESS <u>Westernport</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be filed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 ISM 9/55

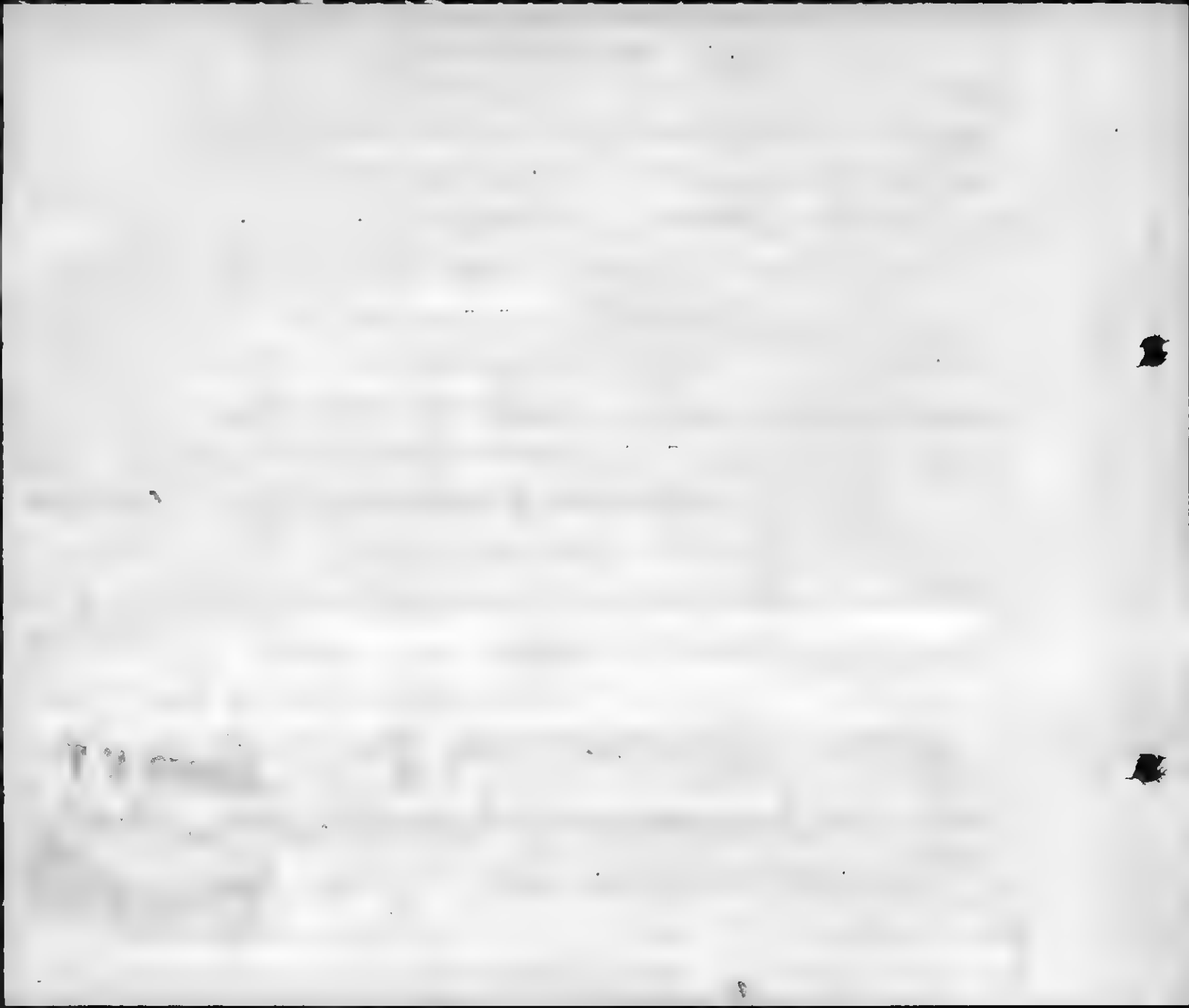
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2357 CERTIFICATE OF DEATH

02356

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>8 days, 12 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>Valley Road, Route #3.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George</u> <u>Watson</u> <u>Cooper</u>				4. DATE OF DEATH Month Day Year <u>3</u> <u>13</u> <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-69</u>	9. AGE (In years last birthday) <u>86</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland City</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania Bedford</u>	
13. FATHER'S NAME <u>Jonathan Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Sarah College Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-10-7806</u>		17. INFORMANT <u>Patient's chart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>PC days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3/4</u> , 19 <u>56</u> , to <u>3/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/12</u> , 19 <u>56</u> , and that death occurred at <u>8:15</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. W. Trevaskis, Sr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Cumberland, Md</u>			
PHYSICIAN'S NAME (Type) <u>R.W. Trevaskis, Sr. M.D.</u>				DATE SIGNED <u>3/13/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chaneyville Meth. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bedford County, Penn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer John J. Hafer</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>March 13, 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>	



2358 CERTIFICATE OF DEATH

Reg. Dist. No.

02357

02357

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 734 Maryland Ave.	
3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last Crawford		4. DATE OF DEATH Month March Day 6 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/10/86
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR Months 6 Days 19 Hours 56	IF UNDER 24 HRS Hours 56 Min 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel McNabb	
14. MOTHER'S MAIDEN NAME Margaret Thomas		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Patient's Chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis & Pericarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) Secondary Anemia			INTERVAL BETWEEN ONSET AND DEATH 4 yrs 10 yrs 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Mar. Day. 5 Year 19 56 Hour 6:05 a. m. PM	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar. 5 , 19 56 , to Mar. 6 , 19 56 , that I last saw the deceased alive on Mar. 6 , 19 56 , and that death occurred at 6:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett M.D.		ADDRESS (Street, city or town, state) Cumberland, Md	
DATE SIGNED 3/7/56			
PHYSICIAN'S NAME (Type) CLAY E. DURRETT CUMBERLAND, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 9, 1956	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HAFERS John J. Hafer,		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR March 8, 1956		24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. AIR FORCE

APR 12 1950

RECEIVED
AIR FORCE
OFFICE

CERTIFICATE OF DEATH

2359

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>1yr. 6mo. 21da.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>near Cumberland, rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>				STREET ADDRESS <u>R.F.D. #3, Bedford Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Catherine</u> (Middle) <u>Matilda</u> (Last) <u>Critzman</u>				(Month) <u>Mar.</u> (Day) <u>21</u> (Year) <u>19 56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>3/4/1875</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Hughs</u>				14. MOTHER'S MAIDEN NAME <u>Margaret (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Melvin Critzman Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Pulmonary Hypostasis</u>				<u>48 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral Arteriosclerosis</u>				?			
18 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile psychosis</u>				<u>3 yrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 4, 19 54</u> , to <u>Mar. 24, 19 56</u> , that I last saw the deceased alive on <u>Mar. 24, 19 56</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Samuel M. Cheau</u> M.D.				ADDRESS (Street, city, town, state) <u>49 Greene St.</u>		DATE SIGNED <u>3-29-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/27/56</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>March 27 1956</u>		REGISTRAR'S SIGNATURE <u>Arther R. Hantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc. Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Labours

WILLIAM V. C.

WILLIAM V. C.

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2410

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Frostburg</u>		LENGTH OF STAY (in this place) <u>8 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>135 S. Water St.</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>EDITH</u> (Middle) <u>(CRUMP)</u> (Last) <u>CROWE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 15, 1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>2-28-1887</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Crump</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Roeder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Frederick Crowe, Frostburg, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1. IMMEDIATE CAUSE (A) <u>Myocardial failure</u>				<u>9 days</u>			
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Heart disease</u>				<u>4 years</u>			
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Metastatic Carcinoma Spine (3+4 DV) from Q. Breast</u>							
19a. DATE OF OPERATION <u>6/26/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Adenocarcinoma left breast</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>November 1954</u> to <u>March 15, 1956</u> , that I last saw the deceased alive on <u>Feb 14, 1956</u> , and that death occurred at <u>1:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William R. Walker M.D.</u>				ADDRESS (Street, city, town, state) <u>M.D. 48 Broadway, Frostburg, Md.</u>			
DATE SIGNED <u>March 15, 1956</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-17-1956</u>		NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR <u>3-17-56</u>		REGISTRAR'S SIGNATURE <u>Mr. Nancy N. Roe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

COMMUNITY

REVIEW

CERTIFICATE OF DEATH

02360

Reg. Dist. No. 4

2360

1. PLACE OF DEATH

COUNTY

ALLEGANY

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN

CUMBERLAND

LENGTH OF STAY (in this place)

36 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

40 HUMBIRD ST

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

MARYLAND

COUNTY

ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN

CUMBERLAND

STREET ADDRESS

40 HUMBIRD STREET

3. NAME OF DECEASED (Type or Print)

(First)

(Middle)

(Last)

BERTHA LUCINDA DARNLEY

4. DATE OF DEATH

(Month)

(Day)

(Year)

MARCH 20 1956

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

WIDOWED

8. DATE OF BIRTH

APRIL 14 1885

9. AGE last birthday

70 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

HOUSEWORK

11. BIRTHPLACE (State or foreign country)

MANNS CHOICE, PA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

ADAM DIEHL

14. MOTHER'S MAIDEN NAME

HANNAH COMP

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT & ADDRESS

MISS EDITH DARNLEY, CUMBERLAND AND MD

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491X IMMEDIATE CAUSE (A) Bronchopneumonia
ANTECEDENT CAUSE(S) DUE TO (B) Heart Bronchitis
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Coronary Stenosis

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

4 days

7 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDIT ON CAUSING DEATH.

Coronary Stenosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED While ☐ at work Not while ☐ at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 19, 1956 to March 20, 1956, that I last saw the deceased alive on March 20, 1956, and that death occurred at 9 P M, from the causes and on the date stated above.

SIGNATURE

Adam S. Murray

M. D.

ADDRESS (Street, city, town, state)

Cumberland and March 22, 1956

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

DATE THEREOF

MAR 24 1956

NAME OF CEMETERY OR CREMATORY

UNION CEMETERY

LOCATION (City, town, or county)

MEYERSDALE PA

24. REC'D BY REGISTRAR

March 23, 1956

REGISTRAR'S SIGNATURE

Walter R. Frantz, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE

Harvey H. Ziegler, Hyndman, Pa.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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DR. JAMES

2361

CERTIFICATE OF DEATH

Reg. Dist. No. **02361**

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE PENNSYLVANIA b. COUNTY Bedford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEDFORD, rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS R.F.D. #3			
3. NAME OF DECEASED (Type or print) First ANNA Middle M. Last DIEHL				4. DATE OF DEATH Month MARCH Day 4 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 5, 1898	
9. AGE (In years last birthday) yrs 57		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE & Nurse				10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME DOUGLAS SOMMERVILLE				14. MOTHER'S MAIDEN NAME MARGARET WALKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 235-34-5744			
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 2 days 2 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Mar. 3 , 19 56 , to Mar. 4 , 19 56 , that I last saw the deceased alive on Mar. 4 , 19 56 , and that death occurred at 6:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William P. James				ADDRESS (Street, city or town, state) 441 N. Centre St. Cumberland, Md.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) WILLIAM P. JAMES							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Mar. 7, 1956		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery	
22d. LOCATION (City, town, or county) Cumberland, Md.				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Light				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 7, 1956	
24b. REGISTRAR'S SIGNATURE W. R. Bantz, M.D.				24c. (City or town)		24d. (State)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Johnnie's

10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044

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24-1-1944

HIMMELWRIGHT

2352

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. STREET ADDRESS 950 MARYLAND AVENUE			
3. NAME OF DECEASED (Type or print) First CHARLES Middle T Last DIFFENDALL				4. DATE OF DEATH Month 3- Day 28 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 16, 1889	
9. AGE (in years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) PENNA. Chambersburg		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker				10b. KIND OF BUSINESS OR INDUSTRY Failroad			
13. FATHER'S NAME JOHN F. DIFFENDALL				14. MOTHER'S MAIDEN NAME ELLEN M. LOUDENSLAGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 705-05-4515			
17. INFORMANT Address MEMORIAL HOSPITAL MEMORIAL AVENUE							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH approx 1 yr.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 1954 , to March 1956 , that I last saw the deceased alive on March 27, 19 , and that death occurred at 6:25 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Overton Himmelwright M.D.				ADDRESS (Street, city or town, state) 133 Virginia Ave DATE SIGNED 3/29/56			
PHYSICIAN'S NAME (Type) G. Overton Himmelwright, M.D. Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3-31-56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cen.	
22d. LOCATION (City, town, or county) (State) Hagerstown, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE James P. Scarpelli Cumberland, Md.				24a. REC'D BY REGISTRAR April 31, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 4 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2420 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 8

- 02363

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u> c. LENGTH OF STAY IN lb <u>36 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beechwood St.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u> X d. STREET ADDRESS <u>Beechwood St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie</u> <u>Dinning</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>30</u> <u>19 56</u>											
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 4-1878</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Airshire-Scotland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Dinning</u>						14. MOTHER'S MAIDEN NAME <u>Jane Houston</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Rebecca Dinning, Lonaconing, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular-renal disease.</u> About <u>3 years</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.															
ACTUAL SIGNATURE <u>H. V. Dening</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED									
EXAMINER'S NAME (Type) <u>H. V. Dening</u> I.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 30-1956</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>				22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>George Eichhorn, Lonaconing, MD.</u>						24a. REC'D BY REGISTRAR DATE <u>4/2/56</u>		24b. REGISTRAR'S SIGNATURE <u>Janette M. Boal</u>							

MEDICAL CERTIFICATION

THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1880

1880

W.F.WMS.

2363

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 16 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. STREET ADDRESS 24 Knobley Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JANE Middle ELIZABETH Last DREYER				4. DATE OF DEATH Month 3 Day 22 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-13-1901	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Making accessories at Kelly Tire Plant &				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ALEXANDER KALSO KALSO				14. MOTHER'S MAIDEN NAME MARY MEAGER MEAGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 214-07-0967			
17. INFORMANT MEMORIAL HOSPITAL				Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphatic Leukemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH July '55							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7:22:1 , 19 55 , to 3:22:1 , 19 56 , that I last saw the deceased alive on 3:21 , 19 56 , and that death occurred at 6:35A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W.F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland			
PHYSICIAN'S NAME (Type)				DATE SIGNED 3/22/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 24, 1956		22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland.							
24a. REC'D BY REGISTRAR March 23, 1956				24b. REGISTRAR'S SIGNATURE W.K. Frantz, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 1/2

2364

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>30 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>414 Grand Ave.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
				d. STREET ADDRESS <u>414 Grand Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Thomas Dulin</u>				4. DATE OF DEATH Month Day Year <u>3 3 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 16, 19 70</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Keyser, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U A</u>	
13. FATHER'S NAME <u>Gabriel A. Dulin</u>				14. MOTHER'S MAIDEN NAME <u>Sarah H. Soule</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. C. F. Pratt, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uraemia</u> DUE TO (b) <u>Myocarditis to decompensation</u> DUE TO (c) <u>5 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jul. 15, 19 56</u> to <u>7 year. 3, 19 56</u> , that I last saw the deceased alive on <u>Jul. 15, 19 56</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clayton J. Jurett</u> M.D.				ADDRESS (Street, city or town, state) <u>Cumberland</u>		DATE SIGNED <u>3/5/56</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-3-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Carlin, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>Mich 6, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Frank, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A. 1900

W. A. R. 1900

2365

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 122 S. LIBERTY ST.			
3. NAME OF DECEASED (Type or print) MR. First HERBERT Middle EARSON Last				4. DATE OF DEATH Month MARCH Day 8 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 20, 1890	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager of News Service				10b. KIND OF BUSINESS OR INDUSTRY News Company			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S..A.			
13. FATHER'S NAME JAMES EARSON				14. MOTHER'S MAIDEN NAME LUCINDA WISE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 214-05-5740			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage with right hemiplegia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) none							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) none			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 1, 1956 to March 8, 1956 that I last saw the deceased alive on March 8, 1956 and that death occurred at 10:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 140 Bedford St. Cumberland, Maryland DATE SIGNED 3/9/56							
ACTUAL SIGNATURE J. H. Wallinan MD				PHYSICIAN'S NAME (Type) J.P. Wallinan M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF March 12, 1956			
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.				22d. LOCATION (City, town, or county) (State) Cumberland MD			
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				24a. REC'D BY REGISTRAR March 12, 1956			
ADDRESS 117 Frederick St.				24b. REGISTRAR'S SIGNATURE W.R. Pearty, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A 100000

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2365

CERTIFICATE OF DEATH

02367

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garfield</u>		c. LENGTH OF STAY IN 1b <u>10</u> yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jane</u> <u>14 E. Frazier Village</u>		d STREET ADDRESS <u>Jane</u> <u>14 E. Frazier Village</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Rose Coddington Ennis</u>		4. DATE OF DEATH Month Day Year <u>March 17, 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1902</u>
9. AGE (In years last birthday) <u>7</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Oakland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Coddington</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia Jamison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Carl V. Ennis</u>		Address <u>Cumberland, Md.</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease - Chronic</u> DUE TO (c) <u>Myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>Years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1954</u> to <u>March 1956</u> that I last saw the deceased alive on <u>March 18, 1956</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>3/18/56</u>	
PHYSICIAN'S NAME (Type) <u>G. Overton Himmelwright, M.D.</u>		ADDRESS (Street, city or town, state) <u>133 Virginia Ave, Cumberland, Md.</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-20-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Oakland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>March 19, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Harty, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LEAU V. S.

1956 02 01

VIEW

2357

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Peter's Hospital</u>				d. STREET ADDRESS <u>507 Woodlawn Terrace</u>			
3. NAME OF DECEASED (Type or print) First <u>T. J.</u> Middle <u>J.</u> Last <u>Wittner</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/2/02</u>	
9. AGE (In years last birthday) <u>45 yrs.</u>		F UNDER 1 YEAR IF UNDER 24 HRS		Months		Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
13. FATHER'S NAME <u>Frank Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Maryland Walker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>216-18-1470</u>		17. INFORMANT <u>Virginia F. Lasser Patient's Chart</u> Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>auricular fibrillation</u> DUE TO (c) <u>rheumatic heart</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 week</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>2-28</u> , 19 <u>56</u> , to <u>3-3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-2</u> , 19 <u>56</u> , and that death occurred at <u>3 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Brings</u>				ADDRESS (Street, city or town, state) <u>57 Green St., Cumberland, Md.</u> DATE SIGNED <u>3-3-56</u>			
PHYSICIAN'S NAME (Type) <u>L. Brings</u>				M.D. <u>L. Brings</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Lee Silcox</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>March 5, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>M. D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

ART

DR. R. J. WILLIAMS 2368 CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 35 DAYS		d. STREET ADDRESS 310 PARK STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TRESA Middle M. Last FRANTZ		4. DATE OF DEATH Month MARCH Day 2 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 9, 1894
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 6 Days 2 Hours 0 Min 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLEANING		10b. KIND OF BUSINESS OR INDUSTRY BOARD OF EDUCATION	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH HEDRICK		14. MOTHER'S MAIDEN NAME Eliza J. H. REXROAD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-22-5555	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the stomach DUE TO (b) Ovarian malignancy DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/15/55 , 19 55 , to 3/2/56 , 19 56 , that I last saw the deceased alive on 3/2/56 , 19 56 , and that death occurred at 4:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. J. Williams M.D.		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 3/3/56	
PHYSICIAN'S NAME (Type) R. J. Williams			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/4/56	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR March 4, 1956		24b. REGISTRAR'S SIGNATURE W. L. Frantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A 07

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2369

Reg. Dist. No.

02370

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		c. LENGTH OF STAY IN 1b <u>7 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(rural) Cumberland</u>	
		f. STREET ADDRESS <u>R.F.D. #3 Valley Rd. /</u>	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gary</u> Middle <u>Lynn</u> Last <u>Gentry</u>		4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 28-1950</u>
9. AGE (In years last birthday) <u>5</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Gentry</u>		14. MOTHER'S MAIDEN NAME <u>Mary H. Weimer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Memorial Hospital records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock; also 1st, 2nd, & 3rd degree burns</u> DUE TO (b) <u>of entire body, except feet.</u> DUE TO (c) <u>Throw gasoline on fire in yard, clothes caught fire.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Boys built a fire</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>gasoline in can was thrown on fire, flare caught clothes</u>	
20c. TIME OF INJURY Month, Day, Year <u>Mar. 4 1956</u> Hour <u>3</u> P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>near home.</u>		20f. (City or town) <u>Cumberland Allegany Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Denning M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Denning M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 8, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>		22d. LOCATION (City, town, or county) <u>near Cumberland, Maryland.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>March 6, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. L. Frank, Jr.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U.S. AIR FORCE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2421 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02371

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>			c. LENGTH OF STAY IN 1b <u>73 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Douglas Ave.</u>				d. STREET ADDRESS <u>Douglas Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>L.</u> Middle <u>Green</u> Last				4. DATE OF DEATH <u>March</u> Month <u>3</u> Day <u>19 56</u> Year				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 4-1882</u>		
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Avilton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Beeman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Crowe</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>(son) John Green, Lonaconing, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> (c), stating the underlying cause last. DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 3-1956</u>				DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crowes Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.F.D. #1 Lonaconing, MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lonaconing, MD.</u>				24a. REC'D BY REGISTRAR <u>DATE 3-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Janette M. Boal</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1

THE UNIVERSITY OF CHICAGO

1957

1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02372

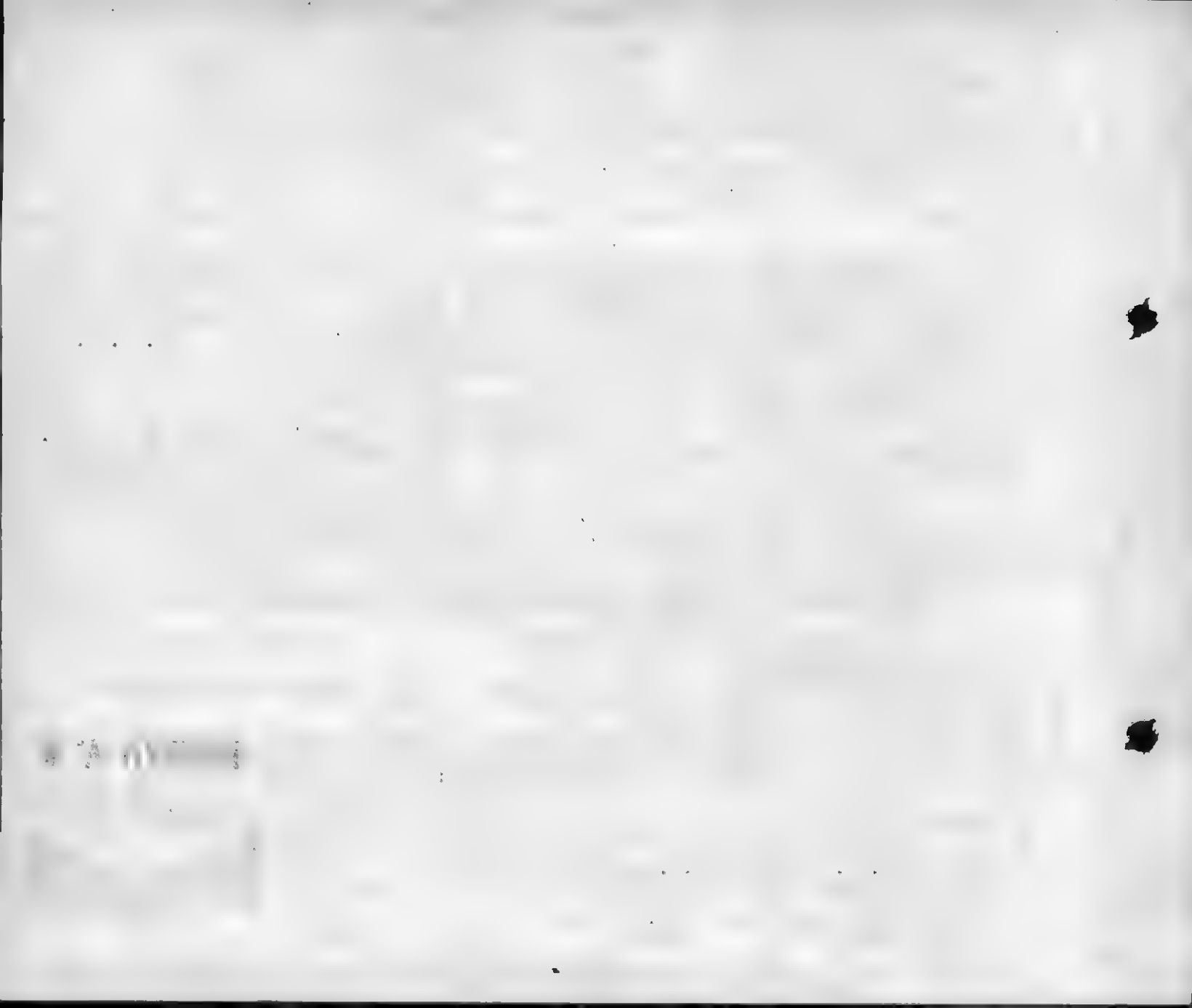
2370

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY MORGAN			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW			
c. LENGTH OF STAY IN 1b 1 DAY				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARIAN Middle J Last GROSS				4. DATE OF DEATH Month MARCH Day 9 Year 19 56			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 10, 1899		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOSEPH CUNNINGHAM				14. MOTHER'S MAIDEN NAME MARY TURNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL WARWICK AND MEMORIAL AVES.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arterio Sclerotic Vascular Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3-8-1956 to 3-9-1956 that I last saw the deceased alive on 3-9-1956 , and that death occurred at 5:19 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. F. Williams M.D.				ADDRESS (Street, city or town, State) Cumberland		DATE SIGNED 3-9-56	
PHYSICIAN'S NAME (Type) W. F. WILLIAMS, M.D.							
22a. BURIAL, CREMATION, OR DISPOSITION (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		March 12, 1956		St. Mary's Cemetery		Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Parks ADDRESS Berkeley Springs, W. Va.				24a. REC'D BY REGISTRAR March 10, 1956		24b. REGISTRAR'S SIGNATURE W. L. Hantz, M.D.	



2371

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10/7/53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 818 Gephart Drive	
3. NAME OF DECEASED (Type or print) First Virginia Middle Growden Last Growden		4. DATE OF DEATH Month March Day 26 Year 1956	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/1874
9. AGE (In years lost b rthday) 81 yrs.		10. UNDER 1 YEAR Months 1 Days 15 Hours 15 Min.	11. UNDER 24 HRS Months 1 Days 15 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Egbert Willison		14. MOTHER'S MAIDEN NAME Victoria Hendrickson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Allegany County Infirmary Records		Address P.O. Box 599	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Hypertrocal Degeneration DUE TO (b) Smile Arteriosclerosis DUE TO (c) Chronic Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH ? ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Central Necrosis (left) - malignant change			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 7th, 1953 to Mar 25, 1956 that I last saw the deceased alive on Mar 25, 1956 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St.,	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		DATE SIGNED 3-26-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 28, 1956	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland.		24a. REC'D BY REGISTRAR Mar 27 1956	
24b. REGISTRAR'S SIGNATURE W.R. Grant, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the attending physician and registrar be filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registrar, the certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

В А ПУМОВ

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

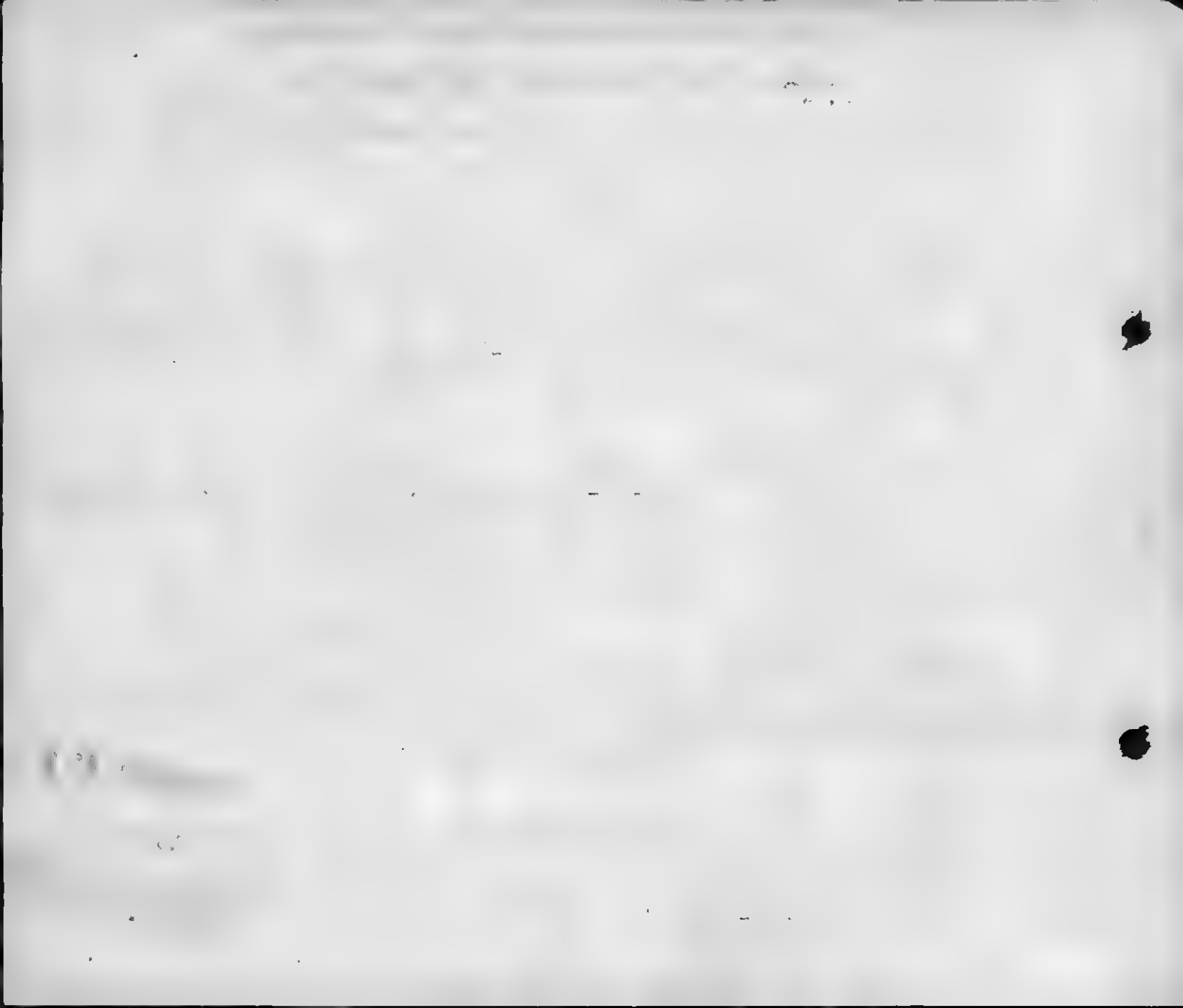
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2411 CERTIFICATE OF DEATH

02374

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		STATE Maryland COUNTY Allegany		CITY (If outside corporate limits, write RURAL and give nearest town) Frostburg		TOWN Frostburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital		LENGTH OF STAY (in this place) 6 days		STREET ADDRESS (If rural give location) 72 College Avenue			
3. NAME OF DECEASED (Type or Print) THOMAS H. GUNTER				4. DATE OF DEATH (Month) March (Day) 9 (Year) 19 56			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 11-22-1888	9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Republican Club		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Gunter				14. MOTHER'S MAIDEN NAME Mary Ann Yates			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) 		16. SOCIAL SECURITY NO. 216-22-6523		17. INFORMANT & ADDRESS Mrs. Nellie Gunter, Frostburg, Md			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Myocardial Insufficiency						INTERVAL BETWEEN ONSET AND DEATH 6 wks	
ANTECEDENT CAUSE(S) DUE TO Hypertension						3 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) 							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 20, 1956, to Mar 9, 1956, that I last saw the deceased alive on Mar 9, 1956, and that death occurred at 11:33 P.M. from the causes and on the date stated above.							
SIGNATURE Wm Lane MD		ADDRESS (Street, city, town, state) Frostburg Md		DATE SIGNED Mar 12, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-12-56		NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		LOCATION (City, town, or county) Frostburg, Md.	
24. REC'D BY REGISTRAR 3-12-56		REGISTRAR'S SIGNATURE Wm Lane MD		25. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst		ADDRESS Frostburg, Md.	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

237 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02375

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>Cumberland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>(rural) Rawlings Station</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dead on arrival, Sacred Heart Hospital-Weyer, Va.</u>		d. STREET ADDRESS <u>Rt. 73</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Helene Marie Hansel</u>		4. DATE OF DEATH Month Day Year <u>March 7 19 56</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22-1899</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Sperlein</u>		14. MOTHER'S MAIDEN NAME <u>Helene Loneice</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>(husband) John W. Hansel, Rawlings Station</u>		Address <u>Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage (apoplexy)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis with hypertention.</u> (c) <u>?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>about 1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 7-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/9/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>March 9, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Frank M.D.</u>	

3 A 070000

10

2373

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. VA. b. COUNTY Orange	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS Route 9.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NELLIE Middle M. Last HENDERSON		4. DATE OF DEATH Month MARCH Day 19, Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 2 1900
9. AGE (n years last birthday) 55		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own House	
11. BIRTHPLACE (State or foreign country) W. VA. Mt. Union		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME PERRY ALDERTON		14. MOTHER'S MAIDEN NAME Vertie Kiwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 1 0 1 6	
17. INFORMANT MEMORIAL HOSPITAL		Address WARWICK AND MEMORIAL AVES.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 442.1 DUE TO (Cardiac Failure) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 244.6 DUE TO Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Diabetes Mellitus. Very marked obesity		INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-18-1956 to 3-19-1956 , that I last saw the deceased alive on 3-19-1956 , and that death occurred at 7:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. H. Williams, M.D.		ADDRESS (Street, city or town, state) Cumberland	
PHYSICIAN'S NAME (Type)		DATE SIGNED 3.20.56	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF March 22 1956	22c. NAME OF CEMETERY OR CREMATORY Mt. Union Cemetery	22d. LOCATION (City, town, or county) (State) Shenandoah, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Henderson		ADDRESS Shenandoah, W. Va.	
24a. REC'D BY REGISTRAR March 21, 1956		24b. REGISTRAR'S SIGNATURE W. K. Hantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2422 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Oldtown, Maryland</u>				TOWN <u>Oldtown, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural, Oldtown, Maryland</u>				STREET ADDRESS (If rural give location) <u>Rural, Oldtown, Maryland</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Wanda Lona Herrell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 27 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 12, 1926</u>	9. AGE last birthday <u>29</u> yrs.	IF UNDER 1 YEAR (Months) (Days)		IF UNDER 24 HRS. (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Paw Paw, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Santymire</u>				14. MOTHER'S MAIDEN NAME <u>Mary Cowgill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Robt. W. Herrell, Oldtown, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Metastatic carcinoma to lung</u>						<u>2 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of left breast</u>						<u>4 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Dec. 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of breast with axillary metastases</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M. <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 1955</u> , to <u>March 27 1956</u> , that I last saw the deceased alive on <u>March 21, 1956</u> , and that death occurred at <u>1:05 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thomas F. Lewis</u>				ADDRESS (Street, city, town, state) <u>M.D. 5 Washington St., Cumberland, Md.</u>		DATE SIGNED <u>3/28/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/30/56</u>		NAME OF CEMETERY OR CREMATORY <u>Crowder Beth. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Organ County, West Virginia</u>	
24. REC'D BY REGISTRAR <u>March 29, 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. Fay Duckworth</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Mafer</u>		ADDRESS <u>Cumberland, Maryland</u>	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED
APR 4 1956
BUREAU OF

2374

CERTIFICATE OF DEATH

02378

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE W. VA. b. COUNTY HAMPSHIRE	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROMNEY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MR. EDWARD Middle HINES Last HINES		4. DATE OF DEATH Month MARCH Day 1 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 3 1872?
9. AGE (in years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Dealer		10b. KIND OF BUSINESS OR INDUSTRY Lumber	
11. BIRTHPLACE (State or foreign country) ROMNEY, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas HINES		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with metastases both lungs DUE TO (b) metastases both lungs DUE TO (c) metastases both lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 14 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 Feb 1956 to 1 Mar 56 , that I last saw the deceased alive on 1 Mar 56 , 1956, and that death occurred at 2:18 PM M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Alfred Van Orme		ADDRESS (Street, city or town, state) Cumberland, Md.	
PHYSICIAN'S NAME (Type) DR. W.A. VAN ORMER		DATE SIGNED 2 Mar 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 4, 1956	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Romney, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Meryl Combs		ADDRESS Romney, W. Va.	
24a. REC'D BY REGISTRAR March 3, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

U. A. C. 1944

1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02379

2375

CERTIFICATE OF DEATH

Item 8, FilmG195 4-12-56 et

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN CumberlandLENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

7 East Elder Street

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MarylandCOUNTY AlleganyCITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN CumberlandSTREET
ADDRESS

7 East Elder Street

3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

EDITH

MAY

HUNT

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

March 31

19

56

5. SEX

Female

6. COLOR OR
RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

Married

8. DATE OF BIRTH

1858

Apr. 20, 1858

9. AGE last birthday

97

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Housewife

10b. KIND OF BUSINESS
OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Town Creek, Maryland

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

DANIEL DE FINEAGH

14. MOTHER'S MAIDEN NAME

ELIZABETH LAVINIA ROSE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS

7 East Elder Street
Eliha C. Huff, Cumberland, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

DUE TO

(C)

18. MEDICAL CERTIFICATION

Chronic Myocarditis
acuteINTERVAL BETWEEN
ONSET AND DEATH

1 year

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

Acute Gastro-Enteritis

24 hours

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
of INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While ☐ Not while ☐
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-31, 1956, to 3-31, 1956, that I last saw the deceased
alive on 3-31, 1956, and that death occurred at 11 P.M. from the causes and on the date stated above.

SIGNATURE

J. T. Johnson

M.D.

ADDRESS (Street, city, town, state)

Cumberland Md

DATE SIGNED

4-3-56

23. BURIAL, CREMATION,
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Apr. 4, 1956

Winter R. Frank, M.D.

John J. Mafer, Cumberland, Maryland

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 153C 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2423

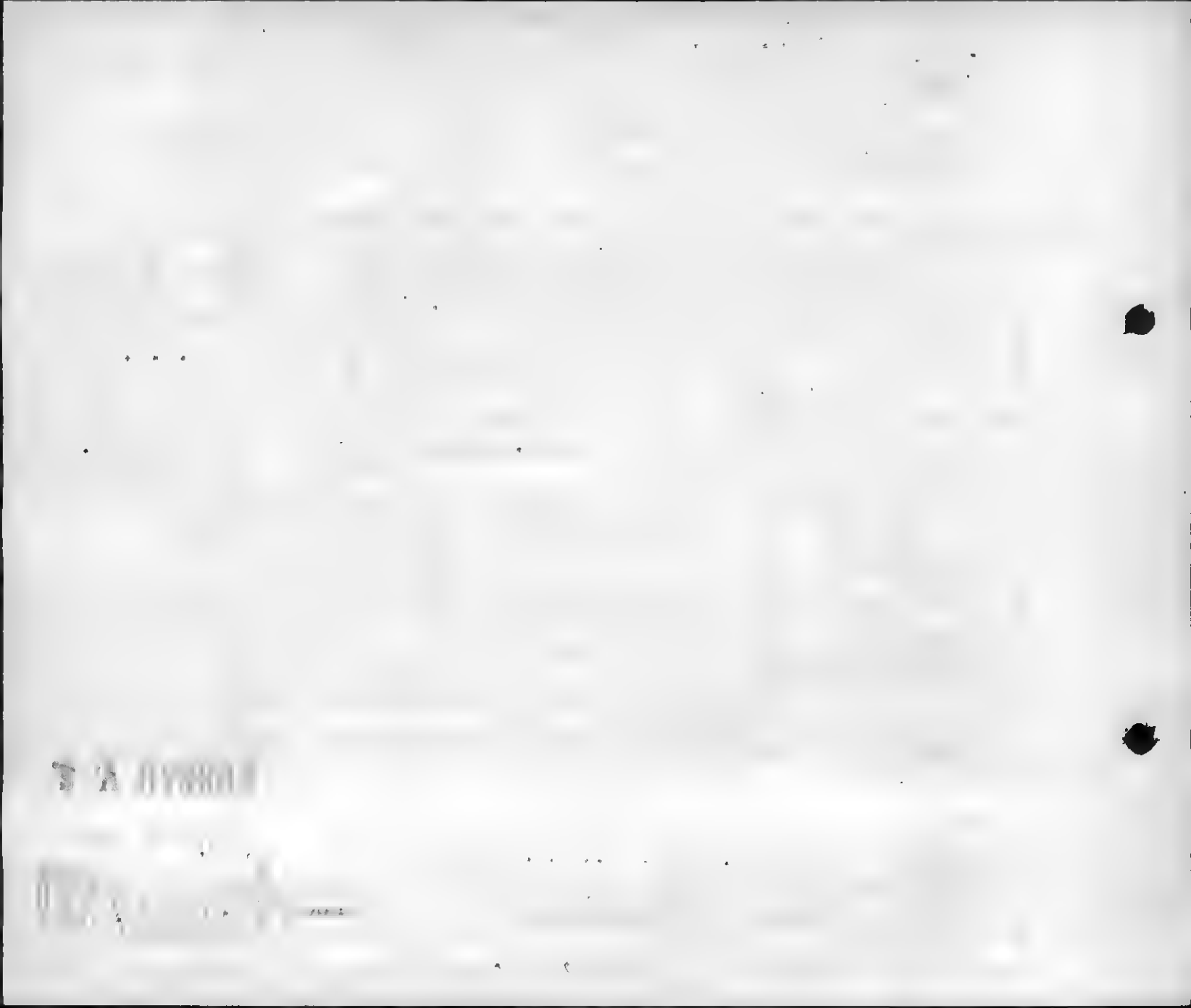
CERTIFICATE OF DEATH

Reg. Dist. No. 802380

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
c. LENGTH OF STAY IN 1b 7 yrs				d. STREET ADDRESS Beachwood Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Janet Louise Isner				4. DATE OF DEATH Month March Day 25 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 10, 1948		9. AGE (In years last birthday) 7 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Isner				14. MOTHER'S MAIDEN NAME Esther Fraley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, no, or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Mrs. Esther Isner Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				"Mother"		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydrocephalus since birth - undetermined				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Mar. 26, 1956 , to Mar. 25, 1956 , that I last saw the deceased alive on Mar. 25, 1956 , and that death occurred at 9 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D. PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D. Lonaconing, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/56		22c. NAME OF CEMETERY OR CREMATORY Oak Hill		22d. LOCATION (City, town, or county) _____ (State) _____ Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE 3-28-56	
				24b. REGISTRAR'S SIGNATURE Jennette M. Boal			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

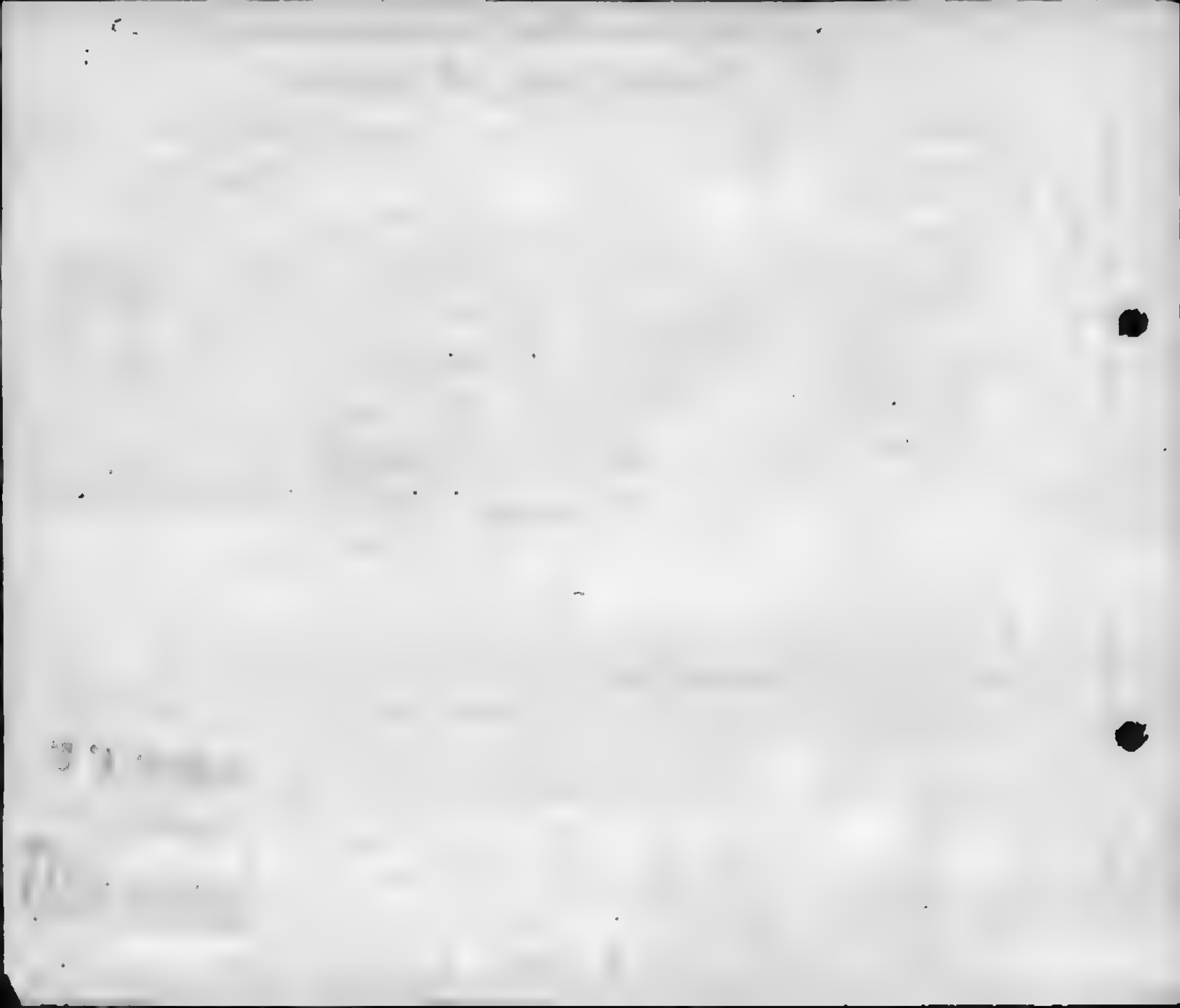
2412

CERTIFICATE OF DEATH

02381

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Frostburg</u>		LENGTH OF STAY (in this place) <u>Lifetime</u>		TOWN <u>Frostburg</u>		TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>11 Welsh Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Catherine</u> (Middle) <u>Jack</u> (Last) <u>Jack</u>				(Month) <u>March</u> (Day) <u>5th</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Nov. 28th, 1883</u>	<u>72</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Ret. Teacher</u>		<u>School Teaching</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel Jack</u>				<u>Mary Monahan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>11 Welsh St., J.Wm. Delaney, Frostburg, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CANCER OF OVARY</u>						<u>10 MONTHS?</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Arteriosclerotic Heart disease</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12</u> <u>3/2</u> <u>56</u> , to <u>19 55</u> , to <u>3</u> <u>3/2</u> <u>56</u> , that I last saw the deceased alive on <u>3/2</u> <u>56</u> , and that death occurred at <u>9 A</u> <u>M</u> , from the causes and on the date stated above.							
SIGNATURE <u>John C. Deane</u> M. D.				ADDRESS (Street, city, town, state) <u>Frostburg Md</u>		DATE SIGNED <u>3/6/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3 - 8 - 56</u>		<u>St. Michael's Cemetery</u>		<u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>3-8-56</u>		<u>Mr. Harvey N. Rose</u>		<u>Joseph R. Durst, Frostburg, Md.</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

2376

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>14.1/2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>			d. STREET ADDRESS <u>1003 Lexington Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Purell</u> Last <u>Johnson</u>			4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>19 56</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11-1918</u>	9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeham</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.M.D.Ry.</u>		11. BIRTHPLACE (State or foreign country) <u>Lanesville, W. Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Joseph S. Johnson</u>			14. MOTHER'S MAIDEN NAME <u>Anna White</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-07-2682</u>		17. INFORMANT <u>(wife) Mary L. Johnson, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-abdominal hemorrhage, also</u> About <u>15 hours.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Ruptured bladder</u> (c) <u>Crushed pelvis. (auto accident)</u> DUE TO cause lost. (c) <u>3-6-1956</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Applied power brake, auto went out of control, thrown to highway.</u>			
20c. TIME OF INJURY Month, Day, Year <u>6.45</u> <u>3-6</u> <u>1956</u> Hour <u>6:45</u> P.M.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway to 28 Ridgeley - Mineral - W. Va.</u>			
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>E. V. Deming M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>E. V. Deming M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 7-1956</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 10, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>The Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Fort Ashby, West Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>			24a. REC'D BY REGISTRAR <u>March 9, 1956</u>		
			24b. REGISTRAR'S SIGNATURE <u>W. L. Frantz, M.D.</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02383

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) City Jail		d. STREET ADDRESS 419 Grand Ave.	
3. NAME OF DECEASED (Type or print) Richard William Keller		4. DATE OF DEATH Month March Day 18 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25-1926
9. AGE (In years last birthday) 30 ym.		IF UNDER 1 YEAR Months 3 Days 18	IF UNDER 24 HRS. Hours 18 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry.	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Russell W. Keller		14. MOTHER'S MAIDEN NAME Martha S. Stoner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) U.S. 2		16. SOCIAL SECURITY NO. 217-19-4972 (brother)	
17. INFORMANT Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 774X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hung himself in the City Jail. (c) Due to (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH (about 10 min.)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury on Part I or Part II, if in 18)	
20c. TIME OF INJURY Month, Day, Year 2 March 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) City Jail		20f. (City or town) (County) (State) Cumberland Allegany Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Dering M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Dering M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 20, 1956	
22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		22d. LOCATION (City, town, or county) (State) near Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland.		ADDRESS	
24a. REC'D BY REGISTRAR March 19, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, written "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2378 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02384

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. at the Memorial Hospital</u>				d. STREET ADDRESS <u>111 W. Old Town Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Violet</u> Middle <u>Cecelia</u> Last <u>Kelley</u>				4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1956</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15-1881</u>			
9. AGE (In years last birthday) <u>74</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Harpers Ferry, W. Va.</u>			
13. FATHER'S NAME <u>Scott Reed</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Levick</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>William T. Kelley, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis</u> (c) <u> </u> DUE TO (a) <u> </u> (b) <u> </u> (c) <u> </u> cause lost. (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u> </u> <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 30-1956</u>				DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>April 3, 1956</u>		<u>St. Mary's Cemetery</u>		<u>Cumberland, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>April 2, 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>				24c. REGISTRAR'S SIGNATURE					

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2379

CERTIFICATE OF DEATH

Reg. Dist. No.

02385

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS Allegany		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle W. Last Kirkwood				4. DATE OF DEATH Month March Day 5 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 9, 1879	
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min 76		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Crane Operator Paper Mill		10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Kirkwood				14. MOTHER'S MAIDEN NAME Mary Duckworth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or date of service) NO		17. INFORMANT Charles Kirkwood Address Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Brother Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cerebral Hemorrhage DUE TO 5 y. (c) Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 1 d	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1952 to 3/5/56 , that I last saw the deceased alive on 3/5/56 , and that death occurred at 2:22 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 51 Main Lonaconing, Md. DATE SIGNED 3-6-56 ACTUAL SIGNATURE George J. Richards, Jr. PHYSICIAN'S NAME (Type) George J. Richards, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 9, 1956		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill		22d. LOCATION (City, town, or county) (State) Moscow, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md.				24a. REC'D BY REGISTRAR March 9, 1956		24b. REGISTRAR'S SIGNATURE W. L. Gentry, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR THE

1948

2424

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Railroad Street		d. STREET ADDRESS Railroad Street	
3. NAME OF DECEASED (Type or print) First Mary Ann Middle Lauder Last Lauder		4. DATE OF DEATH Month 3 Day 31 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31, 1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR: Months 7 Days 10 Hours 10 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Moscow, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Eilbeck		14. MOTHER'S MAIDEN NAME Anna Nicolson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss. Annie Lauder, Lonaconing, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - Cerebral (c) Generalized		INTERVAL BETWEEN ONSET AND DEATH 7 weeks 2-8-56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 19 11 to 3/31 , 19 56 , that I last saw the deceased alive on 3/31 , 19 56 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George Richard M.D. 510 Main		ADDRESS (Street, city or town, state) Lonaconing, Md DATE SIGNED 4-1-56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/3/56	22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	22d. LOCATION (City, town, or county) (State) Moscow, MD.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.		24a. REC'D BY REGISTRAR DATE 4-3-56	
		24b. REGISTRAR'S SIGNATURE Joanette M. Bond	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5507

DR. W.F. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURLINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS	
e. 5. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last EDITH FAY LIKENS		4. DATE OF DEATH Month MARCH Day 16 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 28, 1940
9. AGE (In years last birthday) 15 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED TAYLOR LIKENS		14. MOTHER'S MAIDEN NAME LILLIE EDITH LEATHERMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - MEMORIAL AVE., CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Water Poison - Friederichsen</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Syndrome</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 14 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3.15, 1956</u> to <u>3.16, 1956</u> , that I last saw the deceased alive on <u>3.16, 1956</u> , and that death occurred at <u>12:25 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.F. Williams</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) W. F. Williams, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 18, 1956	
22c. NAME OF CEMETERY OR CREMATORY Knobley Cemetery		22d. LOCATION (City, town, or county) (State) Knobley, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Louis Rowe</u>		ADDRESS <u>Kyer, 2195</u>	
24a. REC'D BY REGISTRAR <u>March 17, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Trant, M.D.</u>	

With corporate limits

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1050

DR. W. F. WMS.

2381

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle E. Last LIVENGOOD				4. DATE OF DEATH Month MARCH Day 30 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9 1886		9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME LEWIS MORRAN				14. MOTHER'S MAIDEN NAME LAURA ENDLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Weak							INTERVAL BETWEEN ONSET AND DEATH One week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 1-17-1956 to 3-30-1956 , that I last saw the deceased alive on 3-30-1956 , and that death occurred at 8:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 3-30-56							
ACTUAL SIGNATURE W. F. Williams, M.D.							
PHYSICIAN'S NAME (Type) W. F. Williams, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		APRIL 2-56		SALISBURY T.O.C.F.		SALISBURY PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Stanley M. Thomas				ADDRESS Salisbury Pa.		24a. REC'D BY REGISTRAR March 30, 1956	
				24b. REGISTRAR'S SIGNATURE W. F. Williams, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU N. 1

1956



2382

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 118 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, rural	
f. STREET ADDRESS Route #6		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. Grace Olive Lucas		4. DATE OF DEATH Month March Day 6 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16 1919
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR: Months 36 Days 0 Hours 0 Min 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receptionist		11b. KIND OF BUSINESS OR INDUSTRY Ins. business	
11c. BIRTHPLACE (State or foreign country) Penn. Espy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Orval Williams		14. MOTHER'S MAIDEN NAME Margaret Berry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 189-09-5931	
17. INFORMANT Memorial Hospital, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, breast, left DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastasis to lung and spine DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 years 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1954 to March 6, 1956 , that I last saw the deceased alive on March 6, 1956 , and that death occurred at 7:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.M. Fawcett Jr		ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED Mar 7 1956	
PHYSICIAN'S NAME (Type) W.M. Fawcett Jr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/9/56	22c. NAME OF CEMETERY OR CREMATORY Madison Memorial Park	22d. LOCATION (City, town, or county) (State) Madison, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR March 9, 1956		24b. REGISTRAR'S SIGNATURE W.H. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 1 1954
U.S. DEPT. OF AGRICULTURE

2383

CERTIFICATE OF DEATH

Reg. Dist. No.

02389

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND, PENNSYLVANIA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS <u>CASH VALLEY ROAD, ROUTE 1</u>			
3. NAME OF DECEASED (Type or print) First <u>OLEY</u> Middle <u>EDWARD</u> Last <u>MCCREA</u>				4. DATE OF DEATH Month <u>#3</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 18, 1887</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>31</u> Hours <u>19</u> Min <u>56</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed attendant Gasoline Station</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PENNSYLVANIA</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>			
13. FATHER'S NAME <u>Shbury McCrea</u>				14. MOTHER'S MAIDEN NAME <u>MARY RUBY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-10-6670</u>			
17. INFORMANT <u>PATIENT'S CHART</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrical hemorrhage</u> <u>4x1010</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterial hypertension</u> (c) <u>arteriosclerotic heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>February 1951</u> to <u>March 31, 1956</u> , that I last saw the deceased alive on <u>March 30, 1956</u> , and that death occurred at <u>7:50 A.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Elizabeth Briggs</u> M.D.				PHYSICIAN'S NAME (Type) <u>ELIZABETH BRIGGS, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>April 3, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glendale Church of Brethren</u>	
22d. LOCATION (City, town, or county) (State) <u>Flintstone Md.</u>				24a. REC'D BY REGISTRAR <u>John J. Hager, Cumberland, Maryland</u>			
24b. REGISTRAR'S SIGNATURE <u>John J. Hager, Cumberland, Maryland</u>				24c. REGISTRAR'S SIGNATURE <u>W. H. Hantz, M.D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Certificate has been signed by the attending physician and completed by the funeral director. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

10

RECEIVED

2384

CERTIFICATE OF DEATH

02390

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/20/55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First George Middle E. Last McDonald		4. DATE OF DEATH Month March Day 19 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/1871
9. AGE (n years last birthday) 84 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John McDonald		14. MOTHER'S MAIDEN NAME Alice Garlitz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO (b) General arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Chronic hepatitis DUE TO (c) Chronic hepatitis		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 20, 1955 to Mar. 19, 1956 , that I last saw the deceased alive on Mar. 17, 1956 , and that death occurred at 2300 M. from the causes and on the date stated above.			
ACTUAL NAME James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		DATE SIGNED 3-19-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/21/56	22c. NAME OF CEMETERY OR CREMATORY Echart Cemetery	22d. LOCATION (City, town, or county) (State) Allegany, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Jonh J. Hafer, Cumberland, Maryland.		24a. REC'D BY REGISTRAR March 21, 1956 24b. REGISTRAR'S SIGNATURE W. L. Hantz, M.D.	

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner jointly filled in by the funeral director. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and coroner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A

2413

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>2 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners</u>		d. STREET ADDRESS <u>RFD #2 Box 131</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>McKenzie</u> Last <u>McKenzie</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 28</u>
9. AGE (In years last birthday) <u>4 yrs</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min <u>2</u>	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>—</u>		13. FATHER'S NAME <u>Edgar McKenzie</u>	
14. MOTHER'S MAIDEN NAME <u>Norah Lane Anderson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT Address <u>Mother RFD #2 Frostburg</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) <u>Pneumature Labor</u> c) <u>Pneumature Labor</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 28, 1956</u> to <u>March 28, 1956</u> , that I last saw the deceased alive on <u>March 28, 1956</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Devers</u> M.D.		ADDRESS (Street, city or town, state) <u>Frostburg, Md.</u> DATE SIGNED <u>3/28/56</u>	
PHYSICIAN'S NAME (Type) <u>John C. Devers</u>		<u>Frostburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-29-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Edgmont Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Edgmont, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Martin Edgmont, Md.</u>		24a. REC'D BY REGISTRAR <u>3-29-56</u>	24b. REGISTRAR'S SIGNATURE <u>Wm. Nancy N. Rae</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 4 1956

BUREAU A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02392

DR. SIMONS

2385

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 17 FIFTH STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle Louis Last MC KENZIE				4. DATE OF DEATH Month MARCH Day 17 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Jan. 28, 1876	
9. AGE (In years last birthday) 80 yrs		F UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired coal miner				10b. KIND OF BUSINESS OR INDUSTRY Coal business		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SAMUEL MC KENZIE				14. MOTHER'S MAIDEN NAME ALICE WINTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,				16. SOCIAL SECURITY NO.			
17. INFORMANT MEMORIAL HOSPITAL - MEMORIAL AVE., CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c) Chronic Hypertension							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 14 Feb. 1956 to 17 Feb. 1956 , that I last saw the deceased alive on 17 Feb. 1956 , and that death occurred at 6:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED March 19, 1956							
ACTUAL SIGNATURE Dr. George M. Simons M.D. Cumberland, Md.							
PHYSICIAN'S NAME (Type) Dr. George M. Simons Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/56		22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.				24a. REC'D BY REGISTRAR March 19, 1956		24b. REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02393

2386

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>115 minutes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>St. Peter's Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
f. STREET ADDRESS <u>437 Henderson Ave.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Lawrence McKenzie</u>				4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-1900</u>	9. AGE (In years last birthday) <u>55</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver-Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Cleaners</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Enoch McKenzie</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Rohman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-5953</u>		17. INFORMANT Address <u>Mrs. Katherine McKenzie Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crownary Thrombosis</u> DUE TO <u>1 day</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO <u>1 yr.</u> (c) <u>Chronic Rheumatic Arthritis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Rheumatic Arthritis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>3-23-56</u> to <u>3-24-56</u> that I last saw the deceased alive on <u>3-23-56</u> , and that death occurred at <u>12:47 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. T. Johnson, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u>			
PHYSICIAN'S NAME (Type) <u>James T. Johnson, Jr., M.D.</u>				DATE SIGNED <u>March 24, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>March 26, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Walter K. Frank, M.D.</u>							

U.S. AIR FORCE

1967

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2387

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>MARIE</u> Last <u>McRAE</u>		4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-86</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE (In years last birthday) <u>69</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM DONAHOE</u>		14. MOTHER'S MAIDEN NAME <u>ANNA WHIP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>PATIENT'S CHART</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis of thoracic</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>And Abdominal viscera</u> DUE TO (c) <u>to death.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10-30-48</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Radical left mastectomy 11-16-48</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-15-1948</u> to <u>3-9-1956</u> that I last saw the deceased alive on <u>3-8-1956</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. J. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>Cumberland</u>	
PHYSICIAN'S NAME (Type) <u>FRED WILLIAMS, M.D.</u>		DATE SIGNED <u>3-12-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/13/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sts. Peter & Paul Cem Cumberland, Maryland</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>HAUER John J. Hauer</u>		24a. REC'D BY REGISTRAR <u>March 13, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>M. J. Hauer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner must sign the certificate. After the certificate is signed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 1/2 075

2425 CERTIFICATE OF DEATH

02395

Reg. Dist. No. 6

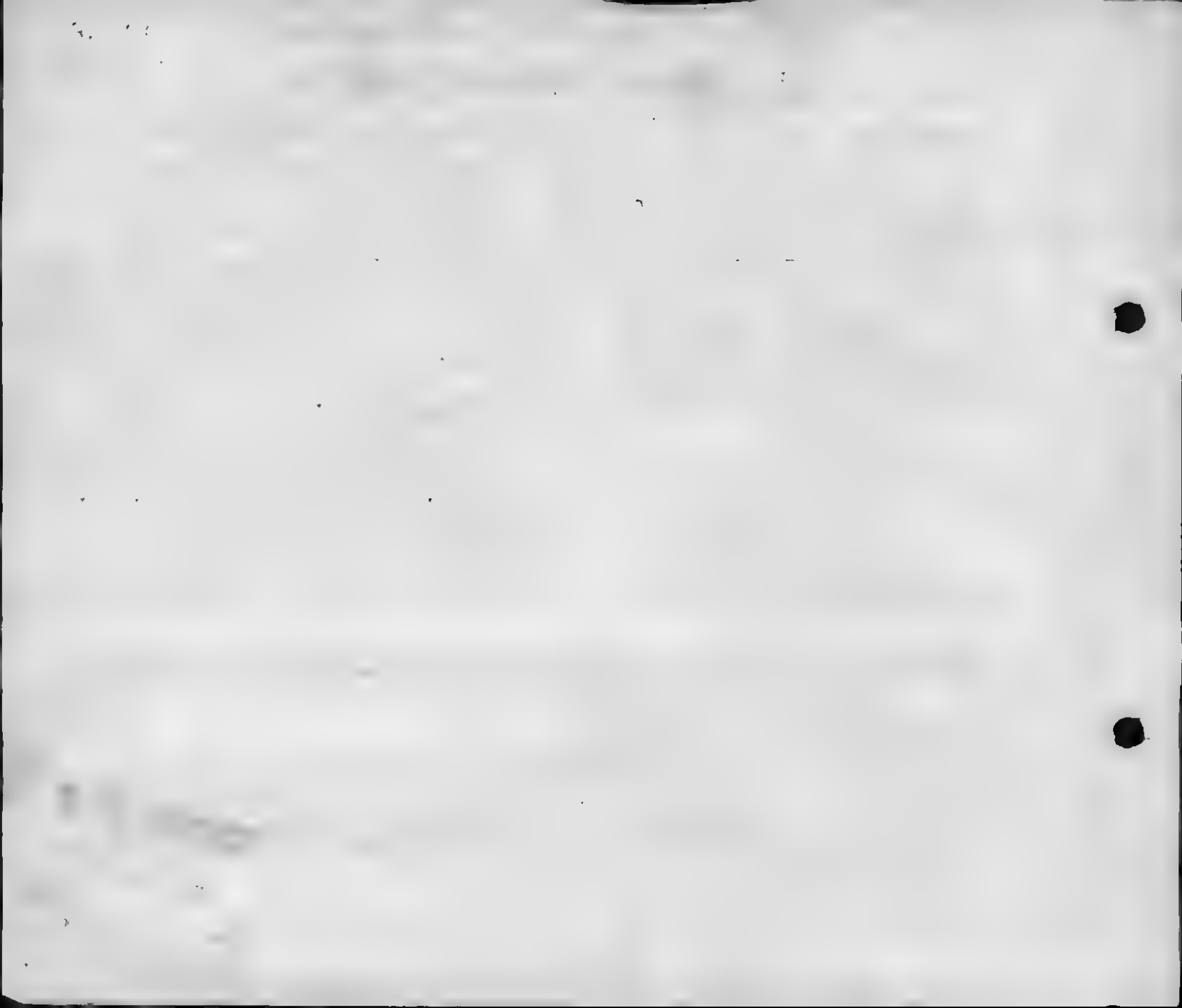
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Barton</u>		LENGTH OF STAY (in this place) <u>75 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Barton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ON</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>James Morris Metz</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>13</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>August 14, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>		11. BIRTHPLACE (State or foreign country) <u>Barton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Metz</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Poland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT & ADDRESS <u>Mrs. Louis Smith, Barton, Md.</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>				<u>10 Years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Silicosis and Anthracosis</u>				<u>10 Years</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 20, 1946</u>, to <u>Mar. 13, 1956</u>, that I last saw the deceased alive on <u>Mar. 12, 1956</u>, and that death occurred at <u>4:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul R. Wilson</u> M.D. <u>Piedmont, W. Va.</u>				DATE SIGNED <u>Mar. 15, 1956</u> (State) <u> </u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		LOCATION (City, town, or county) <u>oscow, Allegany, Md.</u>	
24. REC'D BY REGISTRAR <u>3-15-56</u>		REGISTRAR'S SIGNATURE <u>Ms Jean C Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. ...</u>		ADDRESS <u>Westernport, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2388 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02396

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Cumberland		c. LENGTH OF STAY IN 1b 38 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 543 Henderson Ave.				d. STREET ADDRESS 543 Henderson Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Michael Last Moran				4. DATE OF DEATH Month March Day 8 Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1880 Nov. 21-1880	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired machinest helper-C.Steel Co.				10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, Md.			
13. FATHER'S NAME Daniel Moran				14. MOTHER'S MAIDEN NAME Mary Morrissey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-7071		17. INFORMANT Address (wife) Ella L. Moran, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4301 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH sudden ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED March 8-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 12, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.				24a. REC'D BY REGISTRAR March 9, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File-pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED
MAR 1 1951
LAWRENCE R. E.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 4 must be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2389 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02397

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deaf on arrival at Sacred heart hospital</u>			
d. STREET ADDRESS <u>Calvert St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wilmer</u> Middle <u>C.</u> Last <u>Morris</u>				4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>19 56</u>			
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 7-1914</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>for Blair Bros.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles J. Morris</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Talbott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Seaman Merchant Mar.</u>				16. SOCIAL SECURITY NO. <u>212-10-9661</u>			
17. INFORMANT <u>(Aunt) Mary Talbott, Baltimore, Md.</u>				Address <u>1103 W. 30 St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute peritonitis</u> <u>541.1</u> DUE TO <u>ruptured duodenal ulcer.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>322.2</u> <u>Alcoholic</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Denning M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Denning M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 19-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/20/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u>		(State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>March 23, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Winter L. Frantz, M.D.</u>

U.S. AIR FORCE

1954

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The death certificate has been signed by the attending physician and completely filled in by the funeral director. After the certificate is signed by the funeral director, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		2390		CERTIFICATE OF DEATH		Reg. Dist. No. 4	
1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Mineral</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>415 South Main St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Augustus</u> Middle <u>A.</u> Last <u>Mullen</u>				4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O Railroad Co.</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Thomas Mullen</u>				14. MOTHER'S MAIDEN NAME <u>Anna Ricker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>721-16-9542</u>		17. INFORMANT Address <u>415 S. Main St</u> <u>Chart-- Mrs. A. A. Mullen, Keyser, W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> (c) <u>Multiple Pulmonary Infarcts</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>3/25</u> , 19 <u>56</u> , to <u>3/23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/23</u> , 19 <u>56</u> , and that death occurred at <u>9:45 P.</u> M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>415 N. Centre St.</u>			
ACTUAL SIGNATURE <u>Leo H. Lex Jr.</u> M.D.				DATE SIGNED <u>3/24/56</u>			
PHYSICIAN'S NAME (Type) <u>LEO H. LEX JR. M.D.</u>				<u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas</u>		22d. LOCATION (City, town, or county) (State) <u>Keyser, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. W. Markwood</u>				ADDRESS <u>Keyser, W. Va.</u>		24a. REC'D BY REGISTRAR <u>March 26, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. K. Frantz, M.D.</u>			

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2426

CERTIFICATE OF DEATH

02399

Reg. Dist. No. 2

1. PLACE OF DEATH o. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		d. STREET ADDRESS Jackson Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Street		d. STREET ADDRESS Jackson Street		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Barbara		First Ann		Middle Munson		Last Munson	
4. DATE OF DEATH March 12 1956		Month March		Day 12		Year 1956	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept, 22 1954	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 5 Days 20 Hours Min. 		IF UNDER 24 HRS Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Melvin Munson		14. MOTHER'S MAIDEN NAME Helen Perkins					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. None		17. INFORMANT Melvin Munson, Lonaconing, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Waterhouse-Frydreichsen Syndrome DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Bronchial pneumonia DUE TO (c) Influenza		INTERVAL BETWEEN ONSET AND DEATH 2 hours 6-8 hours 2 d					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1956 , to 12 Mar. 1956 , that I last saw the deceased alive on 12 Mar. 1956 , and that death occurred at 12:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 51 Main Street Lonaconing DATE SIGNED 3-15-56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/56		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN, LONACONING? MD.		ADDRESS GEORGE EICHORN, LONACONING? MD.		24a. REC'D BY REGISTRAR DATE 3-15-56		24b. REGISTRAR'S SIGNATURE Jannette M. Boal	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2391 CERTIFICATE OF DEATH

Reg. Dist. No.

02400

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 33 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 806 GREENE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle Albert Last NICHOLS			4. DATE OF DEATH Month MARCH Day 5 Year 1956				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 20 1887	9. AGE (In years last birthday) 68 yrs	IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired crane operator		10b. KIND OF BUSINESS OR INDUSTRY RAILROADING		11. BIRTHPLACE (State or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOSEPH NICHOLS			14. MOTHER'S MAIDEN NAME JESSIE IRELAND				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, W.W. # 1		16. SOCIAL SECURITY NO. 705-09-8681		17. INFORMANT MEMORIAL HOSPITAL Address MEMORIAL & WARWICK AVES.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abdominal Carcinomatosis DUE TO Primary site - descending colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diffuse myocardial disease - chronic nephritis					INTERVAL BETWEEN ONSET AND DEATH 3 mo.		
20a. DECEASED WAS UNDERLY NO <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2/1/56 , 19 56 , to 3/5/56 , 19 56 , that I last saw the deceased alive on 3/4/56 , 19 56 , and that death occurred at 4 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE RICHARD M. J. WILLIAMS, M.D.		ADDRESS (Street, city or town, state) Cumberland, Md.		DATE SIGNED 3/5/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			
22d. LOCATION (City, town, or county) (State) Cumberland, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 8, 1956			
				24b. REGISTRAR'S SIGNATURE W.R. Prantz, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2427 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02491

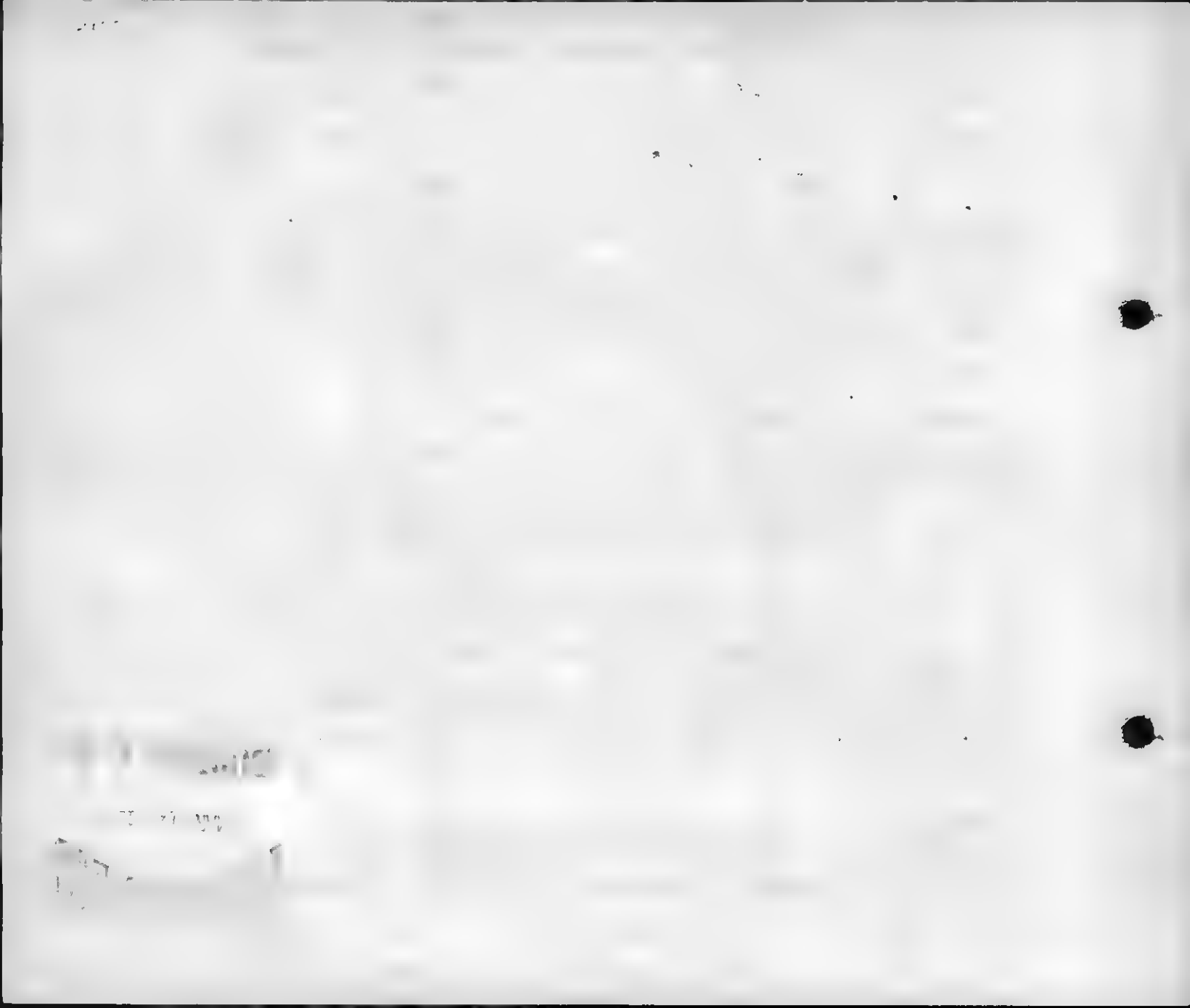
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wt. Savage</u> c. LENGTH OF STAY IN 1b <u>63 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>East Main St.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wt. Savage</u> d. STREET ADDRESS <u>East Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine Jane O'Connors</u>				4. DATE OF DEATH Month Day Year <u>March 9 19 56</u>											
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 26-1872</u>		9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR Months Days Hours M. n.		IF UNDER 24 HRS. Hours M. n.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Rosenbaum Bros.</u>				11. BIRTHPLACE (State or foreign country) <u>Wt. Savage, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Patrick F. O'Connors</u>						14. MOTHER'S MAIDEN NAME <u>Mary Jane Stephens</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-05-6292</u>				17. INFORMATION <u>Sacred Heart Hospital records</u> <u>(Wife) Mrs. Paul Garlitz, Wt. Savage, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock, senility & myocardial failure</u> DUE TO (b) <u>Senility and arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Fracture of right femur, surgical neck.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>?</u> <u>1 month</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>Wiping clothes line</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>in back yard, slipped on ice, fell and fractured femur.</u>											
20c. TIME OF INJURY Month, Day, Year <u>9.30 a.m. Feb. 8 19 56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Back yard, Wt. Savage</u>				20f. (City or town) <u>Allegany</u> (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 9-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>March 12-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Wt. Savage, Allegany, Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. L. Durst</u>						ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR <u>3/10/56</u>				24b. REGISTRAR'S SIGNATURE <u>V. McConnett</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, written and "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



Within corporate limits

2392

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS HOMWOOD ADDITION, R. 7A #1			
3. NAME OF DECEASED (Type or print) First BABy Middle GIRL Last PORTER				4. DATE OF DEATH Month MARCH Day 14 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 13, 1956	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME CHESTER PORTER				14. MOTHER'S MAIDEN NAME JUNE L. SHROYER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL Address MEMORIAL AND WARWICK AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 hrs 15 min							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 3-13-56 to 3-14-56 , that I last saw the deceased alive on 3-14-56 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 411 N. Center St DATE SIGNED W. James							
ACTUAL SIGNATURE W. James M.D. W. James							
PHYSICIAN'S NAME (Type) William James Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 3-17-56		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital, Cumberland, Md.				24a. REC'D BY REGISTRAR March 17, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The "am" requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completely filled in by the funeral director. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 2 1120001

1148

RECEIVED
MAR 11 1961

2414

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
c. LENGTH OF STAY IN 1b 8 hrs.				d. STREET ADDRESS R.D. #2 Box 251			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First James Middle Pelton Last Porter				4. DATE OF DEATH Month 3 Day 31st Year 1956			
5 SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1886		9 AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) Zihlman		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME John Porter				14. MOTHER'S MAIDEN NAME Mahola Crowe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 212-16-8877		17 INFORMANT James A. Porter Address 132 Maple Street Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 101X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with gastric hemorrhage DUE TO (c) Ch. myocarditis						INTERVAL BETWEEN ONSET AND DEATH 6 mos. 10 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterio-sclerosis						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) X (County) (State)			
21. I certify that I attended the deceased from 3-1 , 19 56 , to 3-31 , 19 56 , that I last saw the deceased alive on 3-30 , 19 56 , and that death occurred at 12:30 A. , from the causes and on the date stated above.							
ACTUAL SIGNATURE H.C. Diehl M.D. Frostburg, Md.				DATE SIGNED 3/31/56			
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D., Frostburg, Md.							
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-56		22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Jacob Naper				ADDRESS 23 E. Main Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 4-1-56	
				24b. REGISTRAR'S SIGNATURE Wm. Young, N. Lee			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician and the certificate filled in by the attending physician and completed by the funeral director. After page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 4 1956

BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02404

2393 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jane Frazier Village Apt. 15 D.</u>				d. STREET ADDRESS <u>Jane Frazier Village Apt. 15 D.</u>			
3. NAME OF DECEASED (Type or print) First <u>Willard</u> Middle <u>Lucy</u> Last <u>Hawlings</u>				4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 2-1907</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife and housework for private</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>individuals</u>		11. BIRTHPLACE (State or foreign country) <u>Tunnelton, West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John T. Shrout</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Hartman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-10-6824</u>		17. INFORMANT <u>Mrs. Clarence C. Roby, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the cervix</u> <u>171X</u> DUE TO (b) <u>with metastasis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 20-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 30, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tunnelton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tunnelton, West Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>March 29, 1956 W.R. Frantz M.D.</u>		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 4 1952

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2415 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

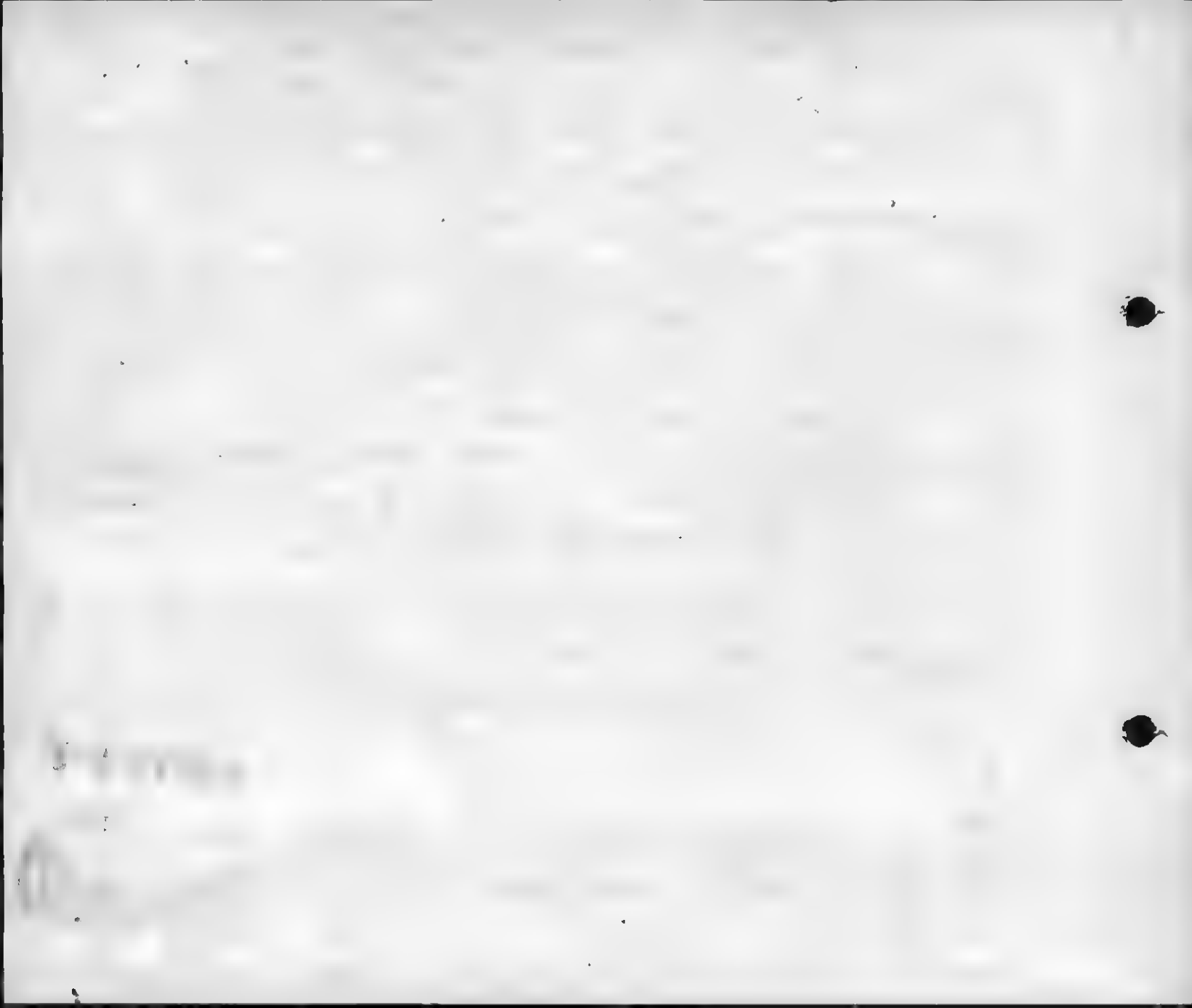
Reg. Dist. No.

02495

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural) Frostburg</u>		c. LENGTH OF STAY IN lb <u>64 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(rural) Frostburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. #3 Midlothian.</u>				d. STREET ADDRESS <u>R.F.D. #3 Midlothian</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edith A. Ritchie</u>				4. DATE OF DEATH Month Day Year <u>March 4 1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Sept. 7-1891</u>				9. AGE (In years last birthday) <u>64</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Midlothian, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edgar Drew</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>(husband) Anthony Ritchie, Midlothian, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis.</u> (c), stating the underlying cause lost. DUE TO </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 5-1956</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3 - 7 - 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>			
22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst,</u> ADDRESS <u>Frostburg, Md.</u>					
24a. REC'D BY REGISTRAR DATE <u>3-7-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Nancy A. Roe</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



2394 CERTIFICATE OF DEATH

02406

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegheny</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>25 yrs</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>535 Columbia Avenue</u>				<u>535 Columbia Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SARAH</u> (Middle) <u>ALPERTA</u> (Last) <u>RUHL</u>				(Month) <u>March</u> (Day) <u>6</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>March 11, 1878</u>	<u>77</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>		<u>Own home</u>		<u>Cumberland Valley, Penn.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>THOMPSON F. HANKS</u>				<u>CATHERINE (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>535 Columbia Avenue</u> <u>Carl F. Ruhl, Cumberland, Maryland</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Infarction</u>				<u>5 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterial Hypertension</u>				<u>2 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 6, 1956</u> to <u>March 6, 1956</u> that I last saw the deceased alive on <u>March 6, 1956</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. W. Trevarick, Jr.</u>				DATE SIGNED <u>3/7/56</u>			
ADDRESS (Street, city, town, state) <u>Cumberland, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/9/56</u>		<u>Greenmount Cemetery</u>		<u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>March 8, 1956</u>		<u>Walter K. Lantz, M.D.</u>		<u>John J. Hafer</u>		<u>Cumberland, Maryland</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2416 CERTIFICATE OF DEATH

02407

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>FROSTBURG</u>		LENGTH OF STAY (In this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>VALE SUMMIT</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>WILLIAM H. SCHILLER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 20 19 56</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JANUARY 16, 1914</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>Johannesburg Somerset Co., PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John C. Schiller</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET WEINOLD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>NORMAN B. SCHILLER CUMBERLAND MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) <u>Cerebral Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Rupture</u>				years-			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 19 55</u> , to <u>March 20, 19 56</u> , that I last saw the deceased alive on <u>March 20, 19 56</u> , and that death occurred at <u>9:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John B. Davis</u>				ADDRESS (Street, city, town, state) <u>Frostburg, Md -</u>		DATE SIGNED <u>3/21/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MARCH 22, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>ST. Johns Cemetery</u>		LOCATION (City, town, or county) (State) <u>Johannesburg, Somerset Co PA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John Henry H. Rie</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne H. Leigler</u>		ADDRESS <u>Lyndman, Pa.</u>	
DATE <u>3-22-56</u>							

U. S. A. 1900

1900

2395

CERTIFICATE OF DEATH

02408

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 Jumberland</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>State Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Desiree</u> Middle <u>Lynn</u> Last <u>Scott</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 23, 1955</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>13</u> Hours <u>19</u> Min. <u>55</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert M. Scott</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Haxley Hickey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Chart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> DUE TO <u>Stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dehydration</u> DUE TO <u>Acute Bronchitis</u> (c) <u>Acute Bronchitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>26 hrs.</u> <u>2 d.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>May 23, 1955</u> to <u>3-13</u> , 1955; that I last saw the deceased alive on <u>3-13</u> , 1955, and that death occurred at <u>11 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Main St., Lonaconing, Md.</u> DATE SIGNED <u>3-14-55</u>							
ACTUAL SIGNATURE <u>George A. Richards, Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>George A. Richards, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. Fehhorn</u>				ADDRESS <u>Lonaconing, Md.</u>		24a. REC'D BY REGISTRAR <u>March 15, 1956 W. R. Frantz, M.D.</u>	
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner must be filled in by the funeral director. After the certificate has been signed by the attending physician and coroner, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.



2396 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Pennsylvania</u> COUNTY <u>Bedford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>6 mos</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Artemas, Pennsylvania</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>761 Layette Street</u> <u>Crumm Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>AMANDA</u> (Middle) <u>JANE</u> (Last) <u>SHIPLEY</u>				Month <u>March</u> Day <u>23</u> Year <u>1971</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 23, 1971</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM F. LETCHER</u>				14. MOTHER'S MAIDEN NAME <u>NANCY WEIMER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Walter Shipley, Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Chr. Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterial Hypertension</u>				<u>18 mos.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1956</u> , to <u>Mar 23, 1956</u> , that I last saw the deceased alive on <u>Mar 20, 1956</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R.W. Trivaskis, Sr.</u>				ADDRESS (Street, city, town, state) <u>M.D. Cumberland, Maryland</u>		DATE SIGNED <u>Mar 24-1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 26, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>fairview Christian</u>		LOCATION (City, town, or county) (State) <u>Artemas, Pennsylvania</u>	
24. REC'D BY REGISTRAR <u>March 26, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter X. Hantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland, Maryland</u>	

BUREAU V. S.

MAR 8

1877

2428

CERTIFICATE OF DEATH

Reg. Dist. No.

6

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution--Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barton</u>		c. LENGTH OF STAY IN 1b <u>65 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Lewis First Harvey Middle Stephen Last				4. DATE OF DEATH March Month 21 Day Year 56 19			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1868</u>	9. AGE (In years lost last day) yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Peter Stephen</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle B roadwater</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, (a) known) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>William Stephen</u>		Address <u>Lonaconing, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Labor Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocarditis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/14</u> , 19 <u>56</u> to <u>3/21</u> , 19 <u>56</u> that I last saw the deceased alive on <u>3/21</u> , 19 <u>56</u> , and that death occurred at <u>6 P</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. E. Berry</u>				ADDRESS (Street, city or town, state) <u>Piedmont W. Va.</u>			
PHYSICIAN'S NAME (Type) <u>P. E. BERRY M.D.</u>				<u>Piedmont W. Va.</u>			
22a. BURIAL, CREMATION, REINTERMENT <u>Buried</u>		22b. DATE THEREOF <u>March 24, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Moscow Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. ... Westernport, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>3-24-56</u>		24b. REGISTRAR'S SIGNATURE <u>M. J. ... Kelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. S.

1900

2397 **CERTIFICATE OF DEATH**

02411

Reg. Dist. No. 4

INSTRUCTIONS

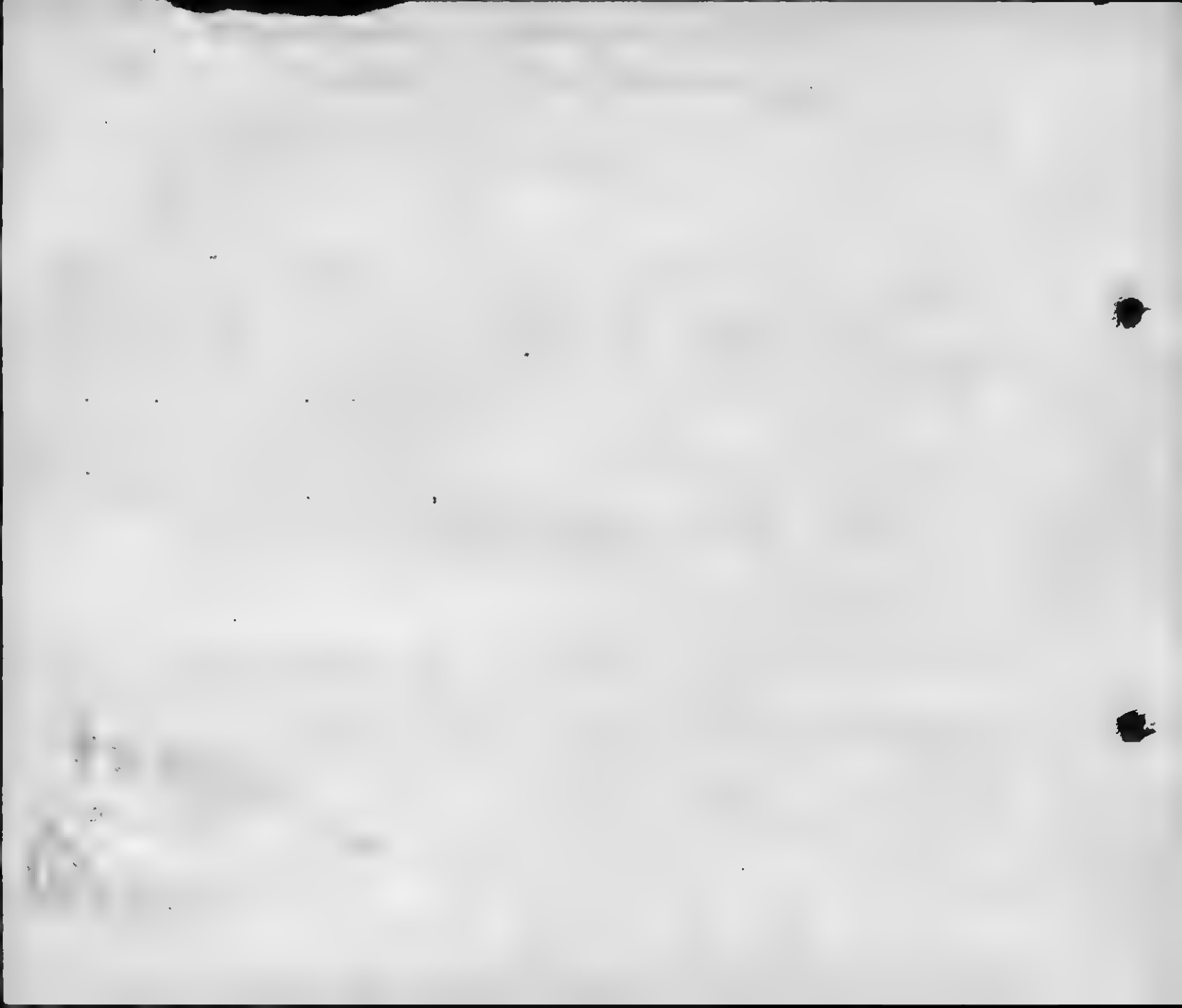
1. WITHIN 24 HOURS after death, the death certificate be executed within 24 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

YS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>11 days</u>		TOWN <u>Westernport</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>		STREET ADDRESS <u>146 Maryland Ave.,</u>					
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Harry</u> <u>Strieby</u>				<u>March 14</u> <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Oct. 1, 1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Warrensville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Strieby</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Ridge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>146, Maryland Ave., Mrs. Alta Frye, Westernport, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1 IMMEDIATE CAUSE (A) <u>4222 Pulmonary Hypostasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u>			
2 ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Hypertension</u>				?			
3 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral Arteriosclerosis</u>				?			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile psychosis</u>				<u>3 yrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 3, 1956</u>, to <u>Mar. 14, 1956</u>, that I last saw the deceased alive on <u>Mar. 14, 1956</u>, and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James B. McLean</u> M.D.				ADDRESS (Street, city, town, state) <u>49 Green St. Westernport, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 18, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Levels Cemetery</u>		LOCATION (City, town, or county) (State) <u>Levels, West Virginia.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Winters R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Boal's Funeral Home, Westernport, Maryland.</u>			



2429

CERTIFICATE OF DEATH

02412

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. # 6 Cumberland,				c. LENGTH OF STAY IN 1b 20 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cresap Drive Bowling Green				e. STREET ADDRESS Cresap Drive Bowling Green			
3. NAME OF DECEASED (Type or print) WILBERT REYNOLDS THEIS				4. DATE OF DEATH Month March Day 31 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1902	9. AGE (In years last birthday) 53 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insulation Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Pittsburg, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Fred Theis				14. MOTHER'S MAIDEN NAME Annie Reynolds			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 217-10-4045		17. INFORMANT Mrs. Margaret E. Theis R. D. # 6 Cumberland, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aortic Aneurism (dissecting) DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-21-56 19, to 3-31-56 19, that I last saw the deceased alive on 3-31-56 19, and that death occurred at 3:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. C. ZIMMERMAN M.D. 3-31-56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/3/56		22c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cem.	
22d. LOCATION (City, town, or county) (State) Pittsburg, Penna.				23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Maryland			
24a. REC'D BY REGISTRAR Phil 3, 1956				24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. R.

APR 4 1900

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

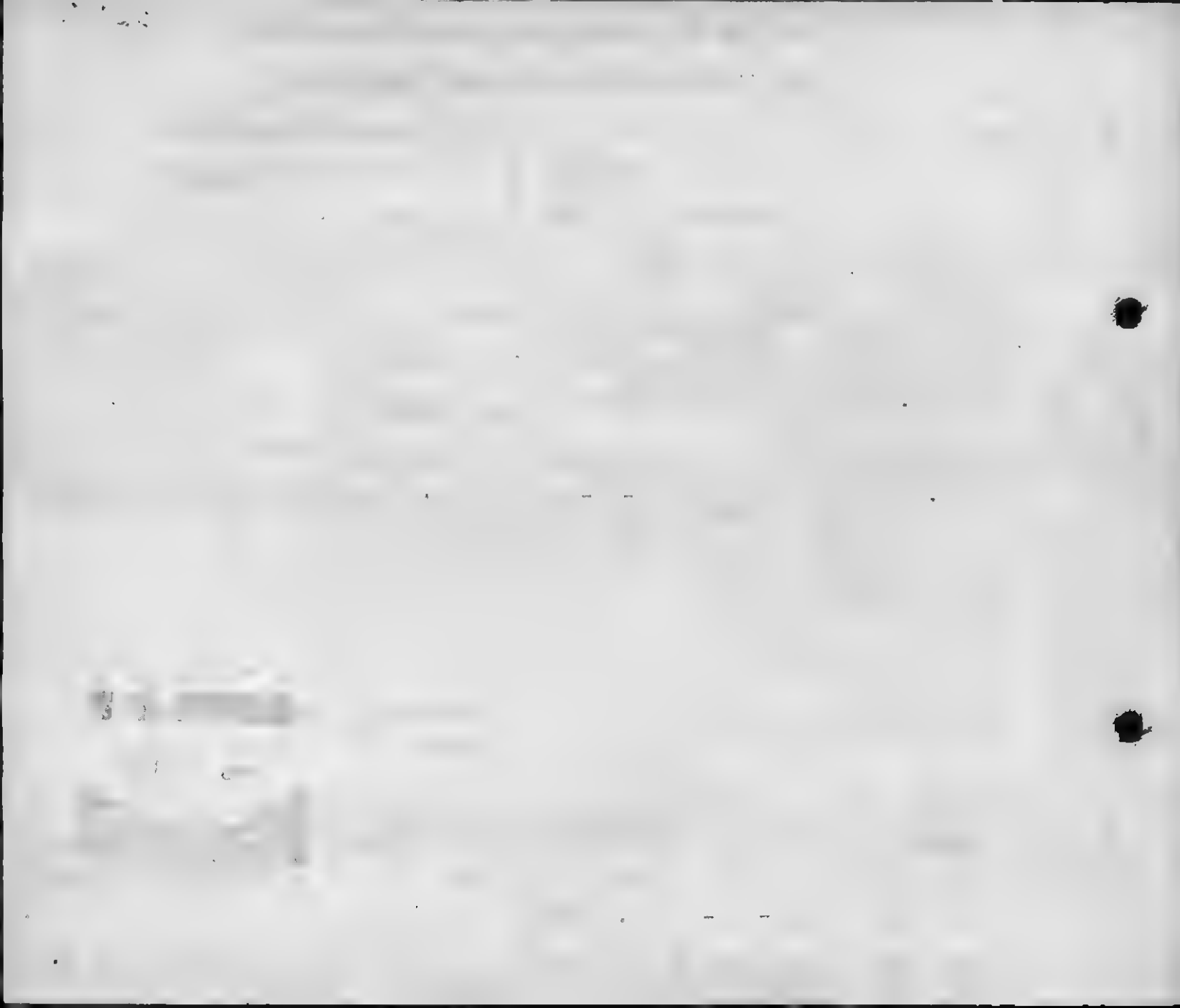
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02413

2430 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		TOWN		TOWN	
X TOWN <u>Route 1, Frostburg</u>		<u>Lifetime</u>		<u>Route 1, Frostburg,</u>		<u>(If rural give location)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Harry</u> (Middle) (Last) <u>Tippen</u>				(Month) <u>March</u> (Day) <u>2nd</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SING., MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Sept. 5th, 1885</u>	<u>70 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Ret. Coal Miner</u>		<u>Coal Mining</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Tippen</u>				<u>Margaret Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>201-10-8576</u>		<u>Mrs. Clara Tippen, RFD 1, Frostburg</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>						<u>1 hr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis, Coronary</u>						<u>Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Silicosis, Advanced</u>						<u>Years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2</u> , 19 <u>54</u> , to <u>2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE <u>John C. [Signature]</u>				DATE SIGNED <u>3/4/56</u>			
ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3 - 5 - 56</u>		<u>St. Michael's Cemetery</u>		<u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>3-5-56</u>		<u>Mr. Nancy N. Roe</u>		<u>Joseph R. Durst, Frostburg, Md.</u>			



DR. W.F. WILLIAMS 2398 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE WEST VIRGINIA b. COUNTY Morgan			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 211 WILKES STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First MIDDLE Last IDA Louise TOBIAS				4. DATE OF DEATH Month Day Year MARCH 22 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1914	
9 AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME STEPHEN PAGENHARDT				14. MOTHER'S MAIDEN NAME Mary McKinnon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO 701		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X <i>Leishmaniasis</i> DUE TO (b) <i>Cirrhosis of Liver</i> DUE TO (c) <i>Cirrhosis of Liver</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11:10, 1955, to 3:22, 1956, that I last saw the deceased alive on 3:21, 1956, and that death occurred at 6:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W.F. Williams</i> M.D. ADDRESS (Street, city or town, state) CUMBERLAND DATE SIGNED 3.22.56							
PHYSICIAN'S NAME (Type) W. F. Williams, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF GEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Mar 24, 1956		Philos Cemetery		Westport MD.	
23 FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
John J. Hafer				Cumberland Md			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
March 23, 1956				W.L. Brantley, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. DEPARTMENT OF AGRICULTURE

1956

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2399 CERTIFICATE OF DEATH

02415

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		STATE Maryland		COUNTY Allegany			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland		LENGTH OF STAY (in this place) 5/14/52		CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				STREET ADDRESS (If rural give location) 735 Fayette Street			
3. NAME OF DECEASED (First) (Middle) (Last) Anna Uhl				4. DATE OF DEATH (Month) (Day) (Year) March 15, 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 12/14/1870	9. AGE last birthday 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Frankfort, Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Christian Weisenmiller				14. MOTHER'S MAIDEN NAME Mario Missie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Allegany County Infirmary Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 422.1 Chronic myocarditis				INTERVAL BETWEEN ONSET AND DEATH ?			
ANTECEDENT CAUSE(S) DUE TO (B) Diffuse arteriosclerosis				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertension				?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile psychosis				3 yrs. -			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 1952 19....., to March 15, 1956 , that I last saw the deceased alive on March 14, 1956 , and that death occurred at 5:30 AM , from the causes and on the date stated above.							
SIGNATURE James B. F. Chace, M.D.				ADDRESS (Street, city, town, state) 49 Greene St.		DATE SIGNED 3-15-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/17/56		NAME OF CEMETERY OR CREMATORY St. Peter & Paul		LOCATION (City, town, or county) (State) Cumberland Maryland	
24. REC'D BY REGISTRAR March 17, 1956		REGISTRAR'S SIGNATURE Walter K. Leary, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Louis Stein, Inc. Cumberland, Md.			

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RECEIVED
MAR 14 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2400 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02416

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>73 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dead on arrival at Sacred H. Hospital</u>				d. STREET ADDRESS <u>473 Baltimore Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u>Fredrick</u> Last <u>Wagner</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1956</u>			
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17-1882</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>73</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Crane operator, S.O.R. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Green Spring, W. Va.</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Wagner</u>				14. MOTHER'S MAIDEN NAME <u>Martha Jane Kerns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-12-3266</u>		17. INFORMANT (Address) <u>(daughter) Mrs. T. Dern, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>440.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>0</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Denning M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Denning M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 19-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>March 20, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Prantzy, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

RECEIVED V. S.

APR 1 1977

107

2431

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Church Street				d. STREET ADDRESS Church Street			
3. NAME OF DECEASED (Type or print) First GEORGE Middle WALLACE Last WALLACE				4. DATE OF DEATH Month 3 Day 16 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec, 22, 1887		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Wallace				14. MOTHER'S MAIDEN NAME Christina Main			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Edward Hunter, Lonaconing, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 322.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension (c) Alcoholism						INTERVAL BETWEEN ONSET AND DEATH Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Nov 28, 1955 to Mar. 1956 , that I last saw the deceased alive on March 15, 1956 , and that death occurred at 1 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Leslie R. Miles, Jr., M.D. Lonaconing, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/18/56		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	
				22d. LOCATION (City, town, or county)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN,				ADDRESS Lonaconing, MD.		24a. REC'D BY REGISTRAR DATE 3-18-56	
				24b. REGISTRAR'S SIGNATURE Jannette M. Bond			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3. A. 1

1
Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02418

2401 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, file third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55-10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>				TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>313 Central Avenue</u>				STREET ADDRESS (If rural give location) <u>313 Central Avenue</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ELLA</u> <u>TELLE</u> <u>WELLS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March</u> <u>22</u> <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 27, 1937</u>		9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MACCELLUS EDWARDS</u>				14. MOTHER'S MAIDEN NAME <u>ANIE ...</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>313 Central Avenue</u> <u>Reginald Wells, Cumberland, Maryland</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Artery</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 24, 1956</u> , to <u>3/22</u> , 1956 , that I last saw the deceased alive on <u>3/22</u> , 1956 , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>George M. L...</u>				ADDRESS (Street, city, town, state) <u>Cumberland, Md</u>		DATE SIGNED <u>3/22/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/24/56</u>		NAME OF CEMETERY OR CREMATORY <u>Sumner Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>March 24, 1956</u>		REGISTRAR'S SIGNATURE <u>W. H. Lantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>			

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11/11/56

2402

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>47 yrs</u>		TOWN <u>Cumberland, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>22 W. Robert St.</u>				STREET ADDRESS (If rural give location) <u>22 W. Robert St.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Elizabeth Whitacre</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3-11-56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 16, 1871</u>		9. AGE last birthday <u>84</u> yrs.	10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Worcester, Bedford Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alexander Holler</u>				14. MOTHER'S MAIDEN NAME <u>Mary Gordon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Anna Shanholtz, 22 W. Robert St.</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Chronic Nephritis & Heart</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension & Atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>None</u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>None</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>			
22. I hereby certify that I attended the deceased from <u>March 10, 1956</u> to <u>March 11, 1956</u> , that I last saw the deceased alive on <u>March 10, 1956</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. H. Holler</u> M.D.				ADDRESS (Street, city, town, state) <u>W. H. Holler, 22 W. Robert St.</u>		DATE SIGNED <u>March 11, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-16-56</u>		NAME OF CEMETERY OR CREMATORY <u>Hyndman Cem.</u>		LOCATION (City, town, or county) (State) <u>Hyndman, Pa.</u>	
24. REC'D BY REGISTRAR <u>March 15, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter X. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Leary</u>		ADDRESS <u>San nelli, Baltimore, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

2403 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02420

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Id. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 110 W. 3rd St.	
3. NAME OF DECEASED (Type or print) Susanne Wickard		4. DATE OF DEATH March 28 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29-1874
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James McLenzie		14. MOTHER'S MAIDEN NAME Sarah McLenzie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Frances Wickard, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis about 8 yrs. DUE TO Arteriosclerosis ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		DATE SIGNED March 28-1956	
EXAMINER'S NAME (Type) H. V. Deming M.D.		DEPUTY MEDICAL EXAMINER March 28-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 31, 1956	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland.		24a. REC'D BY REGISTRAR Apr. 4, 1956	
		24b. REGISTRAR'S SIGNATURE Antonie K. Frantz	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ALBERT V. S.

APR

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02421

2417 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland COUNTY Allegany			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Frostburg		10 days		TOWN Frostburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital				STREET ADDRESS (If rural give location) 134 Bowery St.			
3. NAME OF DECEASED (Type or Print) EMMA W. WILLIAMS				4. DATE OF DEATH (Month) (Day) (Year) March 29, 1956			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 5-5-1897	9. AGE last birthday 58 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Whetstone				14. MOTHER'S MAIDEN NAME Katherine House			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) none		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Cambira Williams, Frostburg, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Cerebral hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 11 days			
ANTECEDENT CAUSE(S) DUE TO (B) Malignant hypertension				2 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Arteriosclerosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3-18 , 19 56 , to 3-29 , 19 56 , that I last saw the deceased alive on 3-29 , 19 56 , and that death occurred at 5 P. M. from the causes and on the date stated above.							
SIGNATURE H. Diehl				ADDRESS (Street, city, town, state) Frostburg, Md. DATE SIGNED 3/30/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4-1-1956		NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		LOCATION (City, town, or county) (State) Frostburg, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Wm. Nancy N. Rze		25. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst		ADDRESS Frostburg, Md.	
DATE 4-1-56							

BUREAU OF

1956

U.S. DEPARTMENT OF AGRICULTURE

2418

CERTIFICATE OF DEATH

02422

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY ALLEGANY				2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LINERS HOSPITAL				d. STREET ADDRESS Lyric Apts., E. Main St.			
3. NAME OF DECEASED (Type or print) First Middle Last CHESTER HARRISON WILSON				4. DATE OF DEATH Month Day Year 3 1st 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-1892		9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kelly Worker		10b. KIND OF BUSINESS OR INDUSTRY Kelly Springfield Shaft, Ind.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Wilson				14. MOTHER'S MAIDEN NAME Rebecca Shell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO 214-07-0045		17. INFORMANT 8625 Flower Avenue, Tacoma Park, Wash.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive myocardial infarction 44001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial damage from DUE TO (c) Previous attack Apr 1955 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity						INTERVAL BETWEEN ONSET AND DEATH 3 hrs 10 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1955 , to 3-1 1956 , that I last saw the deceased alive on 3-1 1956 , and that death occurred at 8 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE H.C. Diehl				DATE SIGNED 3/2/56			
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-4-56		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery Frostburg		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. H. Montesant				24a. REC'D BY REGISTRAR DATE 3-4-56		24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and carefully filled in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 1/2 HOURS

10/10/10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2404

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02423

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>134 Bedford St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Melch</u> Middle <u>Wineow</u> Last <u>Wineow</u>				4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16-1894</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Stanley</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Webster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>(niece) Mrs. Harold P. Smith, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinoma of the uterus.</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 26-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 28, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>March 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Frantz, M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MONDAY 18

1956

15 JUL

2405

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
c. LENGTH OF STAY IN 1b 5 Mo.		d. STREET ADDRESS 210 Paca St.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 210 Paca St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CAROL Middle ANN Last WITT		4. DATE OF DEATH Month March Day 14, Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1955
9. AGE (In years last birthday) yrs. 5		IF UNDER 1 YEAR Months 14 Days 14 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James W. Witt		14. MOTHER'S MAIDEN NAME JoAnn Willison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. James W. Witt		Address 210 Paca St., Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 085.1 Virus Pneumonia - (left) DUE TO (b) measles Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 day 3 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Open Roman Ovale.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-9-56 to 3-15-56 , that I last saw the deceased alive on 3-12-56 , and that death occurred at 12P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 126 Union St., Cumberland, Md. DATE SIGNED 3/15/56			
ACTUAL SIGNATURE H. W. Eliason M.D.		PHYSICIAN'S NAME (Type) Dr. H. W. Eliason	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/56	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR March 15, 1956		24b. REGISTRAR'S SIGNATURE W. R. Harty, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 67 27

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2406 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02425

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		c. LENGTH OF STAY IN 1b <u>15 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>02</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00 247 Columbia St.</u>			d. STREET ADDRESS <u>247 Columbia St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Watkins</u> Last <u>Woltz</u>			4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>19 56</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29-1882</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired nightwatchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Liberty Trust</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Eli Woltz</u>			14. MOTHER'S MAIDEN NAME <u>Katherine Albert</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-05-6097</u>		17. INFORMANT <u>(son) William Woltz, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Myocarditis with hypertention</u> (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Gradual</u> <u>about 2 years.</u> <u>?</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sts. Peter & Paul Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox, Cumberland, Maryland.</u>			24a. REC'D BY REGISTRAR <u>March 6, 1956</u>		
			24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz, M.D.</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 8 1956

RECEIVED